Report to Congress

USAID Child Survival and Health Programs Fund Progress Report

Fiscal Year 2002

U.S. Agency for International Development

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This document was prepared by USAID
in conjunction with
the Population, Health and Nutrition Information Project.

Cover photograph by R. Charbonneau, IDRC.

Dear Reader:

Foreign aid and development have been key elements of American foreign policy since World War II, when the Marshall Plan helped rebuild war-torn Europe. In the recent context of the reconstruction of Afghanistan, humanitarian assistance is now recognized as the third pillar of the response to terrorism, together with military and diplomatic responses. For more than 40 years, the United States Agency for International Development (USAID) has focused on long-range economic, health, and social development assistance efforts, saving and improving the lives of citizens around the world by meeting global health challenges and expanding democracy and free markets. USAID's development efforts are also an expression of the humanitarian spirit of the American people.

USAID's programs in the areas of child survival, maternal health, vulnerable children, HIV/AIDS, other infectious diseases, family planning, and reproductive health serve as a cornerstone of U.S. foreign assistance. The importance of health within the Agency was recently underscored by the consolidation of USAID's health functions in a new Bureau for Global Health. We present here the new Bureau's first report to Congress on the Agency's health activities.

From 1985 to 2002, USAID provided about $5 billion dollars in global health assistance fighting HIV/AIDS, malaria, and tuberculosis, and supporting child survival programs helping the most vulnerable. This report documents examples of programs in which USAID, in collaboration with its partners, has been able to achieve country-level results or other significant accomplishments across its health programs. USAID health programs save millions of lives by supporting immunizations, disease prevention and control including HIV/AIDS, nutrition, sanitation, hygiene, voluntary family planning, breastfeeding, birth spacing, and other health interventions. We're excited to share with you here some of the recent success stories.

Yet, despite these important successes, approximately 11 million children under the age of 5 die every year, the vast majority of them from preventable and treatable diseases such as measles, diarrhea, and pneumonia. Four out of every 10 people lack access to basic sanitation; 42 million people live with HIV/AIDS; and each passing day nearly 10,000 people in sub-Saharan Africa are newly infected with the virus. There is much more for us to do. The need for continued United States global health leadership is apparent. Equally apparent is the need to further expand and grow partnerships as we continue forward to reduce child and infant illness, improve maternal and reproductive health, and fight the HIV/AIDS pandemic and other infectious diseases. We hope in reading this report you will find a place to join with us to reduce the suffering of men, women, and children around the world.

Dr. E. Anne Peterson, MD, MPH

Assistant Administrator, Global Health

Contents

Acronyms and Abbreviations

AEEB	Assistance to Eastern Europe and the Baltic States
AFR	USAID Bureau for Africa
AFR/SD	USAID Bureau for Africa/Office of Sustainable Development
AIDS	Acquired immunodeficiency syndrome
AMR	Antimicrobial resistance
ANE	USAID Bureau for Asia/Near East
ARI	Acute respiratory infection(s)
BASICS	Basic Support for Institutionalizing Child Survival
CAR	Central Asia Republics
CARE	Cooperative for Assistance and Relief Everywhere, Inc.
CDC	Centers for Disease Control and Prevention (U.S.)
CORE Initiative	Communities Responding to the HIV/AIDS Epidemic Initiative
CORE Group	Child Survival Collaborations and Resources Group
CPF	Commodity Promotion Fund
CSD	Child Survival and Disease Program Fund
CSH	Child Survival and Health Programs Fund
CSGP	Child Survival Grants Program
CS/MH	Child survival and maternal health
DCHA	USAID Bureau for Democracy, Conflict and Humanitarian Assistance
DCOF	Displaced Children and Orphans Fund
DHS	Demographic and Health Survey
DOTS	Directly observed treatment, short-course (TB)
DPT	Diphtheria, pertussis, tetanus
DPT3	Three DPT immunizations received before age 1
DR Congo	Democratic Republic of the Congo
E&E	USAID Bureau for Europe and Eurasia
ESF	Economic Support Fund
FP/RH	Family planning and reproductive health
FSA	Freedom Support Act
FY	Fiscal year
G/CAP	Central America Regional Program
GAIN	Global Alliance for Improved Nutrition

Acronyms and Abbreviations *(continued)*

GAVI	Global Alliance for Vaccines and Immunization
GDF	Global TB Drug Facility
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GH	USAID Bureau for Global Health
HIV	Human immunodeficiency virus
IAVI	International AIDS Vaccine Initiative
ID	Infectious diseases
IDD	Iodine deficiency disorder (Kiwanis International/UNICEF partnership program)
IDRC	International Development Research Centre
IMCI	Integrated Management of Childhood Illness
Int'l Partners	International Partnerships
ITN	Insecticide-treated bednet
IUD	Intrauterine device
JHU/CCP	Johns Hopkins University Center for Communication Programs
LAC	USAID Bureau for Latin America/Caribbean
LAC/RSD-SPO	Latin America Regional Sustainable Development – Strategy & Program Office
NID	National immunization day
ORS	Oral rehydration salts
ORT	Oral rehydration therapy
PAHO	Pan American Health Organization
PEI	Polio Eradication Initiative
PPC	USAID Bureau for Policy and Program Coordination
PVO	Private voluntary organization
RBM	Roll Back Malaria
REDSO/East	USAID Regional Economic Development Services Office for East Africa
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VC	Vulnerable children
WARP	USAID West African Regional Program
WHO	World Health Organization

Executive Summary

Since the 1960s, USAID has been committed to improving the health and well-being of children and families, promoting reproductive health, and helping to safeguard the world against infectious diseases, including HIV/AIDS. Since 1985, when the U.S. Congress created the Child Survival Initiative, USAID has obligated more than $5 billion in support of initiatives in child survival, reproductive health, HIV/AIDS, and other infectious diseases. This report for fiscal year 2002 documents examples of programs in which USAID, in collaboration with its partners, has accomplished significant gains and progress in these key areas of public health concern in developing countries.

In fiscal year 2002, USAID health programs were funded principally from the Child Survival and Health (CSH) Programs Fund, but also received funding from the Economic Support Fund (ESF), the Freedom Support Act (FSA), the Assistance to Eastern Europe and the Baltic States (AEEB) account, and Food for Peace (Public Law 480). Total amounts shown below include funding from all these accounts.

Funds were allocated to the following categories:

Child Survival and Maternal Health: $391.7 million for immunizations, nutrition, maternal health, activities to strengthen health systems, and other core child and maternal health programs. This included $27.5 million for polio eradication and $33.8 million for micronutrient deficiencies. CSH funds accounted for $320 million of this amount.

With Congressional support,

USAID's program has evolved and expanded:

- In 1986, USAID began its support for activities to combat HIV/AIDS.
- In 1997, USAID's programs in child survival, maternal health, HIV/AIDS, and basic education were placed into the newly created Child Survival and Disease Program Fund.
- In 1998, USAID added the Infectious Disease Initiative, which focuses on tuberculosis, malaria, antimicrobial resistance, and disease surveillance, to its program portfolio.
- In 2001, Congress created the vulnerable children funding category to better address the needs of displaced children, orphans, children with disabilities, and other vulnerable children.
- In 2002, USAID's family planning and reproductive health programs were placed within the new Child Survival and Health Programs Fund, while basic education activities were moved to the Development Assistance account.

Vulnerable Children: $32.3 million for programs that benefit displaced children and orphans, blind children, other vulnerable children, and orphanages in Eastern Europe and Eurasia. CSH funds constituted $25 million of the total for this category.

HIV/AIDS: $501.3 million supported prevention, care, and treatment programs and other activities to mitigate the impact of the HIV/AIDS pandemic. This included $435 million from the CSH account.

Other Infectious Diseases: $182 million ($165 million from the CSH account) supported activities to reduce the threats of infectious diseases of major public health importance, particularly tuberculosis and malaria.

Family Planning and Reproductive Health: $446.5 million supported family planning and reproductive health programs, helping families achieve their desired family size while protecting the health of women and children. This included $368.5 million from the CSH account.

USAID programs have continued to achieve results for families in the developing world. Recent highlights include:

Immunizations: USAID is a leader in the global fight to halt vaccine-preventable diseases. Thirty years ago, less than 5 percent of the developing world's children were immunized against measles, diphtheria, pertussis, polio, and tuberculosis. Today, more than 70 percent of children living in developing countries are protected against these diseases. Immunization programs prevent 2 million child deaths annually. USAID's Boost Immunization Initiative, launched in 1999, has expanded to 20 countries where USAID is working to improve basic immunization services. In five countries that have participated in "Boost" since the beginning – Democratic Republic of the Congo, Dominican Republic, Ethiopia, Ghana, and Mozambique – immunization coverage has risen by more than 20 percent. USAID has continued its leadership role in the Global Alliance for Vaccines and Immunization (GAVI), both as a member of the governing board and a participant in all GAVI task forces. GAVI and its Vaccine Fund are now supporting enhanced immunization programs in over 60 countries.

Polio Eradication Initiative: With assistance from USAID ($27.5 million in support in fiscal 2002) and other donors, the global campaign to eradicate polio has prevented more than 5 million polio cases since its inception in 1988. Fewer than 1,900 confirmed cases have been reported for 2002.

Nutrition: To address malnutrition, USAID promotes breastfeeding, improved feeding practices for children and women, and micronutrient supplementation and fortification. In 2002, USAID helped 19 countries conduct semiannual vitamin A supplementation campaigns, up from six in 1999. Increased vitamin A intake has been shown to reduce deaths in children by up to 30 percent. In addition, USAID was instrumental in creating the Global Alliance for Improved Nutrition to promote food fortification in developing countries.

Control of Diarrheal Diseases: Use of oral rehydration therapy, one of USAID's leading child survival interventions, continues to increase. Survey data show that in USAID-assisted countries two out of three children with diarrheal illness receive this treatment. The World Health Organization estimates that infant and child mortality from diarrheal diseases – once the leading killer of children in developing countries with more than 4 million deaths annually – has declined to about 1.5 million deaths per year. Diarrhea prevention through hygiene improvement is also an essential element of child health programs. USAID is assisting global efforts to "scale up" programs for clean water and sanitation, with the goal of halving the number of people without access to improved sanitation by 2015. Such initiatives include support for a public-private partnership to promote hand washing in Peru and Nepal.

Maternal and Neonatal Health: USAID's maternal and neonatal health programs help communities prepare for births by promoting the attendance of skilled personnel at delivery, improving self-care, recognizing complications, and finding means to arrange transport and pay

for care. USAID-assisted countries that have seen substantial declines in maternal mortality from pregnancy-related causes in the last 10 to 15 years include Egypt (52 percent decline), Honduras (41 percent), Bangladesh (22 percent), and Morocco (8 percent).

Vulnerable Children: USAID activities on behalf of vulnerable children improve the safety and security of children affected by war, poverty, disabilities, and other risk or crisis situations. With an emphasis on family and community support, USAID promotes the development, psychosocial well-being, and social integration of these children. Last year, approximately 370,000 children benefited from activities supported by USAID's Displaced Children and Orphans Fund.

HIV/AIDS: In 2002, USAID developed an operational plan to accelerate implementation of its "expanded response strategy" and maximize its impact. USAID supports key partnerships such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and has established grant programs to ensure that communities and organizations on the front lines of the pandemic have access to resources. USAID field staff assist in drafting applications to the Global Fund and are poised to help grant-receiving countries implement their proposals. This year, USAID made progress in introducing antiretroviral treatment and developing new prevention technologies. USAID is helping to alter the course of national HIV/AIDS epidemics in countries such as Bolivia, Cambodia, Uganda, and Zambia.

Tuberculosis Control: USAID provides global leadership and supports expansion of the "directly observed treatment, short course," or DOTS, treatment strategy to combat TB, the world's leading curable cause of death. In 2002, USAID supported the implementation and expansion of DOTS in 35 countries.

Malaria: During 2002, USAID assisted 22 national malaria programs and three regional initiatives, continuing to build malaria control networks and develop new technologies and approaches. In Africa, USAID launched new malaria prevention activities in Ghana, Nigeria, Senegal, and Zambia through NetMark, a public-private partnership to promote the use of insecticide-treated bednets. NetMark sold more than 600,000 nets and 500,000 insecticide re-treatments during its first five months of operation. Use of bednets can reduce malaria-related mortality by up to 63 percent and morbidity by at least 40 percent, particularly among children under age 5 and pregnant women, and has the potential to save more than 1 million lives a year in Africa.

River Blindness: USAID was the largest bilateral contributor to the Onchocerciasis Control Program to prevent river blindness in 11 West African countries. The Program declared victory in 2002 after protecting more than 40 million people from river blindness and preventing 600,000 cases. It also helped re-establish agriculture on more than 25 million hectares of arable land once abandoned due to the disease. The increase in agricultural production is enough to feed an additional 17 million people annually.

Family Planning and Reproductive Health: USAID provides assistance to family planning and reproductive health programs in more than 65 countries. Family planning can help couples space their births at least three years apart, a practice that can reduce infant and maternal deaths by one-quarter. Surveys also indicate that use of family planning reduces abortion. In recent years, significant increases in modern contraceptive use have occurred in countries that once lagged far behind the global average. In Zambia, for example, the Demographic and Health Survey reported in 2002 that 22.6 percent of married women were using a modern contraceptive method, an increase from 14.4

percent in 1996. Uganda has reported a more than twofold increase in modern contraceptive use, from 7.8 percent in 1995 to 18.2 percent in 2001. USAID also supports contraceptive research and development and has tested an important natural family planning method. This new method, known as the "Standard Days Method," has been found more than 95 percent effective in clinical trials and will increase informed choice and access to family planning.

Research: USAID is a leading supporter of operations, biomedical, and social science research, and also promotes innovative technology and program development. Current USAID-supported research is studying prevention of mother-to-child HIV transmission, malaria vaccine development, microbicide development, and the impact of micronutrient supplementation on childhood illness. In 2002, USAID support was instrumental in the launch of a new formulation of oral rehydration salts as well as the World Health Organization's endorsement of zinc as a safe and effective treatment for diarrhea in children.

PVO Partnerships: This year the Child Survival Grants Program provided support to 25 private voluntary organizations in 33 countries. Projects ranged from providing training to community health workers in Peru to encouraging African women to seek care at health facilities when their children are sick.

I. Making Health Programs Work

Numerous factors influence the success of health programs. These almost always involve a combination of evidence-based and cost-effective strategies, solid partnerships, and national coverage.

Focusing on Proven, Cost-Effective Interventions

The most prevalent health problems of people in the developing world – premature mortality of mothers and children, high fertility, and ill health and malnutrition that reduce the potential of individuals, families, communities, and countries – result from a relatively limited set of diseases and health conditions. Many of these conditions can be addressed by simple, cost-effective, evidence-based interventions. In child survival, for example, oral rehydration therapy and basic childhood immunizations have saved millions of children's lives; simple antibiotic treatment for pneumonia and new vaccines can save millions more. Voluntary family planning programs have contributed to declines in infant mortality and also reduced the burden of high population growth rates in poor countries such as Bangladesh. In infectious diseases, the potential of straightforward interventions is being realized in the "directly observed treatment, short course," or DOTS, approach to tuberculosis, simple drug treatment for pregnant women with malaria, and the use of insecticide-treated bednets for malaria protection.

However, sound policies are needed for these fundamental interventions to be effective. They must be delivered in ways that can be achieved and sustained by the health care capacity that exists in a given country. Because the success of these interventions usually depends on the choices and actions of families themselves, communication investments and support for positive behavior change are also necessary. In the end, all of these interventions ultimately focus on – and measure their performance by – getting these basic interventions to the people that need them.

Partnerships for Impact

In all countries that USAID serves, partnerships are critical for achieving successful results. Partnerships must be maintained on three levels:

- Partnerships with countries
- Partnerships with other donors and organizations
- Participating in formal global alliances

Partnerships with countries are fundamental. All of USAID's child survival and health programs are carried out in the context of bilateral agreements with the governments of host countries. For this reason, and to achieve impact, these programs have to be adapted to the policies, health care capabilities, and resources that exist in each country. The presence of USAID country missions allows for this partnership to be ongoing and dynamic.

Partnerships with other donors and organizations allow the different external partners of each developing country to combine their efforts and apply the "comparative advantages" of each. Donor resources play an important role in host countries by providing additional inputs that enable governments and local populations to achieve an optimum return on their own investments in health. Among donors, USAID stands out for its technical capabilities, its direct engagement in country-level programming, its understanding of how to work with nongovernmental and private sector partners, and its monitoring of results.

USAID has long-standing successful partnerships with community- and faith-based organizations, nongovernmental organizations, and private voluntary organizations. With a strong focus on community-level implementation, such groups have been highly effective and efficient in implementing USAID programs around the world. Faith-based organizations are now partners in 10 percent of USAID's HIV/AIDS activities, and their participation in the fight against HIV/AIDS will continue to grow.

Child immunization activities in the Democratic Republic of the Congo provide an excellent example of such complementary partnerships. USAID provides technical assistance and support for actual immunizations, while the United Nations Children's Fund (vaccine purchase and logistics), the World Health Organization (policy leadership and coordination with the government), and a countrywide network of faith-based and nongovernmental organizations (community-level health care) each in its way contributes to improved immunization coverage under very difficult circumstances.

Global alliances are the newest sources of support and coordination available to developing countries for building health care programs. These partnerships include the Global Alliance for Vaccines and Immunization; the Global Fund to Fight AIDS, Tuberculosis, and Malaria; and the Global Alliance for Improved Nutrition. These alliances involve partnerships at the international level for policy and strategy development and resource generation. They also involve country-level partnerships for program coordination and implementation. Most alliances are not sufficient into themselves – they must be supported by constituent members.

In addition, USAID is using its expertise to help private sector partners make investment decisions and bring new partners and ideas to the international development arena. USAID looks for opportunities where prudent investments of relatively small amounts of capital can generate much larger benefits in the achievement of overall objectives. The Global Alliance for Improved Nutrition exemplifies the new approach to providing aid.

As the resources from these new alliances increasingly reach countries, they will provide new challenges and opportunities for partnership at all three levels – with countries, with donors and organizations working at the country level, and within the alliances themselves. Countries and their donor partners will need to adjust their support and approaches to take the greatest advantage of the resources provided. At the same time, creative uses of in-country coordinating bodies (required for use of alliance funds) will be necessary to increase overall coordination and effectiveness.

Planning For and Achieving Scale

In addition to evidence-based, cost-effective interventions and their supporting partnerships, strategies and programs need to aim at achieving national coverage and scale. For the global community, achieving success actually means succeeding at the national level in country after country.

Achieving national scale must be a part of planning for all child survival and health programs. Programs must fit within available resources, garner the support of partners, and be focused, simple, and feasible enough to be carried out on a national scale. When innovation is required to make an intervention work, it must be developed and implemented according to these criteria. When initial demonstration phases are required, they should be part of a plan for broader implementation. The "endgame" should be maximum coverage of families through approaches that countries and their partners can sustain with reasonable resources. Progress toward this end needs to be measured and monitored. Programs that have achieved national

scale in a number of developing countries around the world include contraceptive social marketing, the DOTS treatment strategy for tuberculosis, and vitamin A supplementation for young children.

Putting All the Pieces Together

USAID's goal is to achieve national impacts – such as reductions in unintended, mistimed pregnancies; reduced under-five mortality; reductions in adverse childbirth-related outcomes for mothers and newborns; reduced HIV transmission and impact of HIV/AIDS; and reduced threat of infectious diseases such as tuberculosis and malaria – in targeted countries. USAID accomplishes this goal by supporting the highest priority, most cost-effective interventions; by joining in partnerships with host countries and other donors; and by implementing programs on a national scale. This report documents examples of programs in which USAID, in collaboration with its partners, has been able to achieve country-level and other significant results.

II. Child Survival and Maternal Health

Photo by IDRC/Charbonneau, R.

II. Child Survival and Maternal Health

Immunizations

The importance of routine immunizations as a critical child health intervention continues to grow. Infectious diseases are an ever-present threat in developing countries, and the relative lack of quality disease treatment programs underscores the importance of immunizations against vaccine-preventable diseases. Maintaining high immunization coverage can provide protection against outbreaks of killer diseases such as measles, which (as recently occurred in Tanzania) can sweep through entire towns and villages.

Routine immunization services currently reach more than 70 percent of the world's children, protecting against tuberculosis, polio, pertussis (whooping cough), measles, diphtheria, and tetanus. With support from the Global Alliance for Vaccines and Immunization (GAVI) and its Vaccine Fund, the scope of immunization services is expanding to include hepatitis B, *Haemophilus influenzae* type b (a primary cause of childhood pneumonia), and yellow fever.

USAID Strategy and Interventions

Critical challenges confront immunization programs. These include expanding immunization services to all children, reducing the number of children who do not complete all immunization series, improving the quality of services (including injection safety), and ensuring the sustainability of national programs.

USAID works in partnership with multilateral and bilateral organizations, nongovernmental organizations, private voluntary organizations, and national immunization programs. USAID matches its advantages with its partners' strengths to form a complementary, comprehensive approach.

USAID's immunization strategy has four critical elements:

- Improving the quality of immunization through better vaccine handling and safe injection practices
- Increasing coverage through increased demand
- Introducing new and underutilized vaccines into strengthened routine immunization programs
- Strengthening disease control for measles mortality reduction and polio eradication

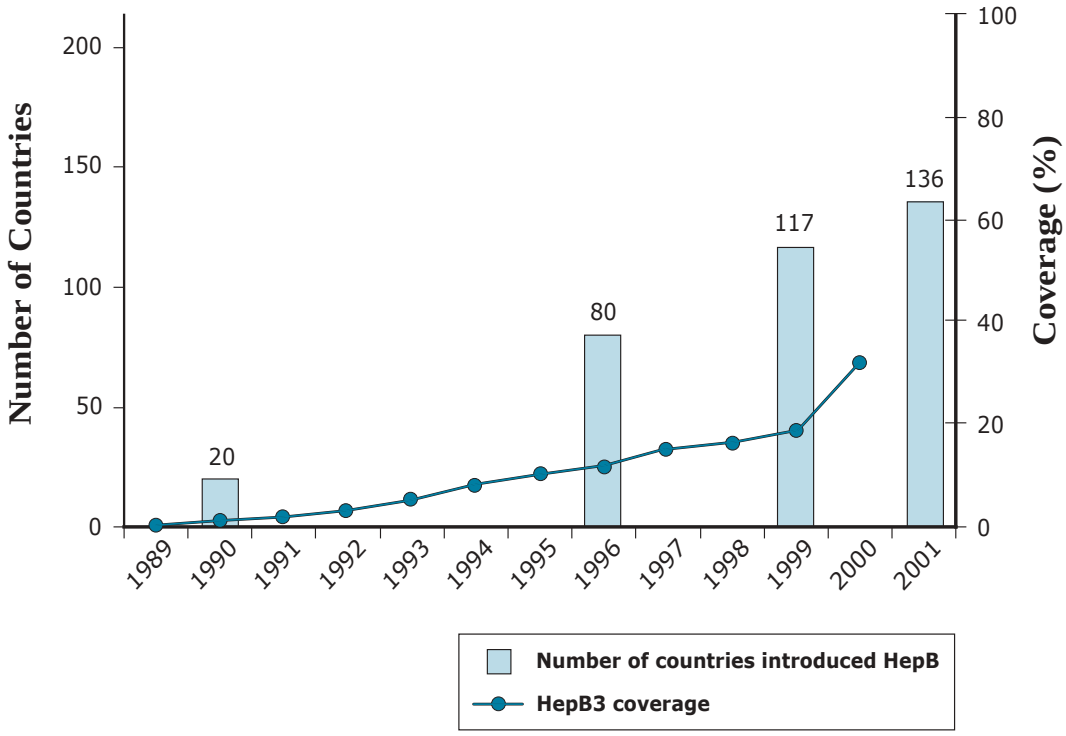
GAVI and the Vaccine Fund. USAID continues its successful partnership with GAVI and the Vaccine Fund, GAVI's financing mechanism. Along with other GAVI partners, including national governments, multilateral organizations, private foundations, nongovernmental organizations, and the vaccine industry, USAID supports GAVI's goals of:

- Improving access to sustainable immunization services
- Expanding the safe use of all cost-effective vaccines

Photo by Franco, R.

Figure 1

Countries Introducing Hepatitis B Vaccine and Global HepB3[1] Coverage, 1989-2001



Source: WHO/UNICEF joint reporting form, 2000 & WHO country information, 2001.
http://www.who.int/vaccines-surveillance/documents/SlidesGlobalImmunization_Aug_19_2002.ppt
[1] Three consecutive doses of hepatitis B vaccine by age 6 months

- Accelerating research and development efforts for new vaccines most needed in developing countries
- Promoting program sustainability by ensuring adequate financing
- Making immunization coverage a key indicator of development
- Reinforcing global and national immunization goals, including polio eradication, elimination of maternal and neonatal tetanus, reduced impact of measles, and increased access to vitamin A

USAID is closely involved in GAVI activities. USAID's Assistant Administrator for Global Health serves on the GAVI Board. USAID also represents bilateral donors on the GAVI Working Group, serves as co-chair of GAVI's Financing Task Force, and is significantly involved with the Advocacy and Implementation Task Forces. USAID's ongoing immunization programs also serve as a critical component to GAVI at the country level.

GAVI's accomplishments to date include:

- Financial support to 24 countries for national immunization programs and the provision of new and underused vaccines to 27 countries. As a result, a growing number of countries have expanded, or will soon expand, their programs to include immunizations against hepatitis B (27 countries), *Haemophilus influenzae* type b (seven countries), and yellow fever (four countries).
- Creation of a viable market in poor countries for simple-to-use vaccines that com-

bine new and old antigens, including a combined hepatitis B, diphtheria, pertussis, and tetanus vaccine. Vaccine manufacturers are striving to satisfy the demand for this vaccine. Seven suppliers are making significant investments in vaccine development and production capacity to meet the needs of new national programs.

The United States government remains a generous supporter of GAVI's Vaccine Fund. Through USAID, the United States has contributed $100 million to the Fund in the past two years, the largest of seven government contributions. The Fund raises resources for developing countries to improve infrastructure, introduces new and underused vaccines, and provides safe injection equipment. Since 2000, the Fund has committed nearly $1 billion to 60 countries to use over five-year periods. If the programs reach the targets they have set, basic immunization rates in these countries will rise by an average of 16 percentage points. Coverage of hepatitis B vaccine will increase from 19 to 65 percent by 2007, ultimately saving more than 2 million lives.

Key Achievements

Boost Immunization Initiative. In 1999, USAID launched its Boost Immunization Initiative to strengthen national immunization programs in USAID-assisted countries where vaccination coverage rates were lagging. Through the Boost Initiative, USAID has substantially increased its investment in immunizations and revived its global leadership role. In 2002, the Boost Initiative expanded to 20 countries where USAID Missions are working to improve basic immunization coverage. This renewed focus is already having an impact in priority countries, as suggested by increases in coverage for diphtheria, pertussis, and tetanus (DPT3), the standard indicator of completed immunizations. For example, in the Democratic Republic of the Congo, the Dominican Republic, Ethiopia, Ghana, and Mozambique – five countries with significant Boost investments – DPT3 coverage

Global Partnering for Measles Mortality Reduction

With an estimated worldwide mortality of 770,000 deaths annually, measles remains the most serious vaccine-preventable disease. Measles accounts for approximately half of all mortality from vaccine-preventable diseases, with most of these deaths occurring in children under age 5. Because measles is highly contagious, even high routine immunization coverage can fail to prevent outbreaks.

Measles mortality is closely related to vitamin A deficiency. Many African countries have both low immunization coverage and high levels of vitamin A deficiency, resulting in a significant measles problem. Africa alone accounts for approximately 60 percent of all the world's measles deaths.

To address measles mortality, USAID technical staff have worked closely with the World Health Organization and the United Nations Children's Fund (UNICEF) to craft the "Measles Mortality Reduction and Regional Elimination Strategic Plan, 2001-2005." This plan provides a comprehensive approach based on strengthened routine immunization services, expanded opportunities for children to receive measles vaccine, improved measles surveillance, and vitamin A supplementation for children to prevent the consequences of measles infection. USAID and its partners have also mapped out strategic approaches to measles outbreaks in complex emergencies and other settings. In the Democratic Republic of the Congo, USAID is working with UNICEF to implement supplemental immunizations in a way that strengthens routine immunization activities and provides lasting benefits beyond measles prevention.

Photo by Franco, R.

increased from about 45 percent in 1999 to an estimated 55 percent in 2001. In the Democratic Republic of the Congo, DPT3 coverage increased from 10 to 40 percent, an especially impressive accomplishment because of the difficult conditions in that country.

Reducing Immunization Dropouts in Senegal. USAID has launched an intensive program in Senegal to reduce the number of children who do not complete their scheduled immunizations. In 15 districts where USAID is supporting immunization services, DPT3 coverage increased from 44 percent in 2001 to 65 percent in 2002.

Increased Immunization Coverage in Cambodia. The USAID-sponsored immunization program in Cambodia has achieved remarkable success in increasing the percentage of fully immunized children. The three provinces receiving USAID assistance maintained steady increases in coverage from 46 percent in 1996 to more than 70 percent five years later.

Support for Madagascar's National Program. USAID has contributed to a major turnaround in Madagascar's national immunization program. In USAID-assisted provinces, 87 percent of children are fully immunized, compared with 44 percent for the rest of the country.

Completing Immunization Series in Nepal. USAID has provided technical assistance to a community volunteer program that monitors children with incomplete vaccinations and encourages mothers to have their children complete their immunizations. In just five months, the proportion of children not completing their three DPT vaccinations decreased from 32 to 12 percent in one district and from 42 to 25 percent in another.

Decentralizing Immunization Program Management in the Dominican Republic. In a three-province project to strengthen local health management capacity in the Dominican Republic, USAID has helped provincial staff gain experience in immunization program management. In project areas, *Haemophilus influenzae* type b immunizations are up 40 percent.

Restoring Georgia's National Immunization Program. Socioeconomic turmoil in the early 1990s in Georgia badly disrupted the nation's health care system, including its immunization services. In 1993 and '94, DPT3 coverage fell as low as 30 percent, with outbreaks of pertussis occurring as a result. USAID and other donors responded by supporting vaccine supplies, cold-chain equipment for temperature control of vaccines, and capacity-building initiatives that helped the government re-establish high immunization coverage. In 2001, DPT3 coverage was 86 percent.

II. Child Survival and Maternal Health

Polio Eradication Initiative

The United States is one of the leading bilateral donors in the global campaign to eradicate polio. Since 1996, USAID has allocated more than $200 million to its Polio Eradication Initiative. In 2002, USAID programmed $27.5 million for polio eradication.

The global eradication campaign has prevented more than 5 million cases of paralysis since its inception in 1988. More than 120 countries now have national task forces preparing to meet post-eradication surveillance and containment needs. The World Health Organization (WHO) has a global network of 135 accredited laboratories to test and report suspected polio cases from every country in the world. USAID support has been instrumental in these achievements. In addition to USAID and WHO, the leading "polio partners" include Rotary International, the United Nations Children's Fund (UNICEF), and the Bill & Melinda Gates Foundation. Private voluntary organizations, nongovernmental organizations, and private sector corporations also participate in the campaign.

For 2002, 1,891 cases of confirmed poliovirus have been reported from seven countries. This number is larger than the 497 cases reported for 2001, largely due to outbreaks in Kano and Kaduna states, Nigeria, and Uttar Pradesh, India. Such outbreaks are the result of poor immunization coverage, which allows poliovirus to persist undetected as the number of susceptible children grows. Increased collection, analysis, and use of district-level surveillance data can help identify areas in need of improvement.

To eliminate polio completely, it is more important than ever for the eradication program to reach marginalized populations repeatedly overlooked by vaccinators.

Given the persistence of remaining pockets of poliovirus in some endemic countries, virus transmission was not interrupted by the end of 2002 as once envisioned. The 2005 goal of global certification of polio eradication may also need to be revised. In the meantime, ongoing polio transmission has implications for financing, advocacy, and the eventual feasibility of global certification. USAID is working with its partners to revise the global timeframe.

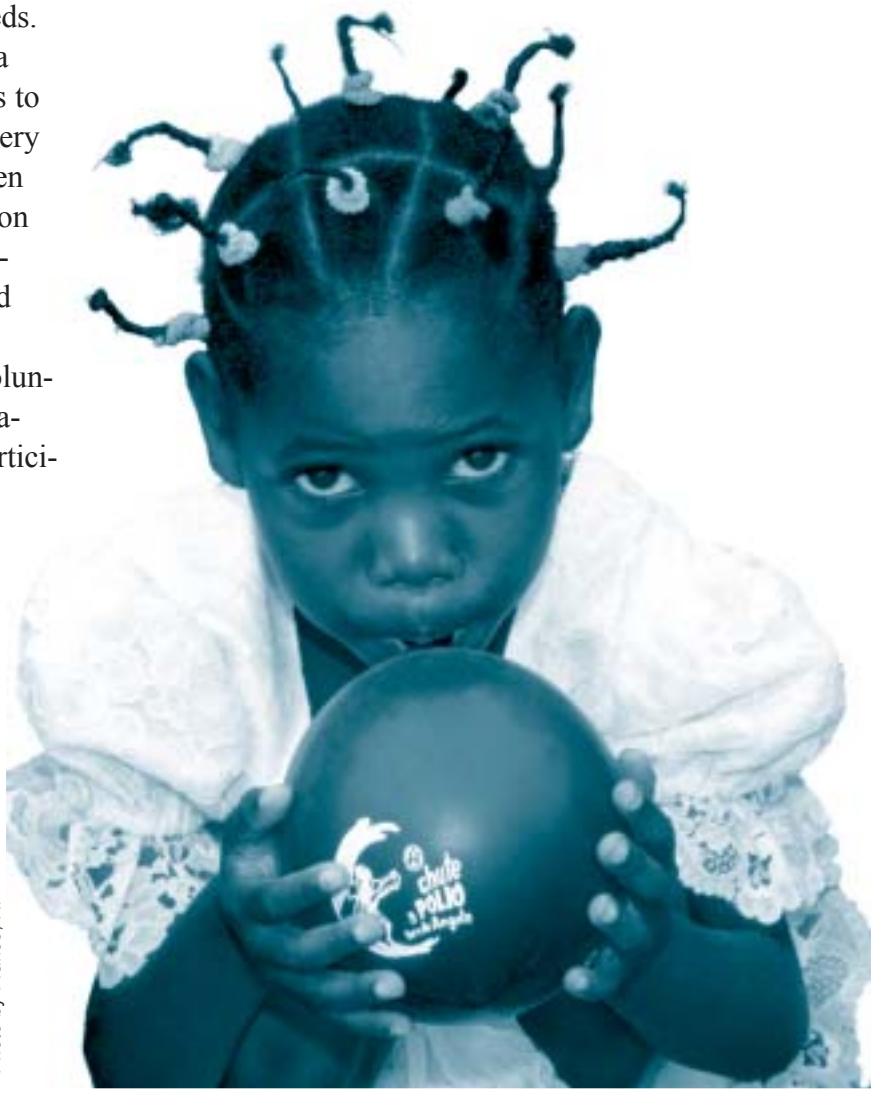
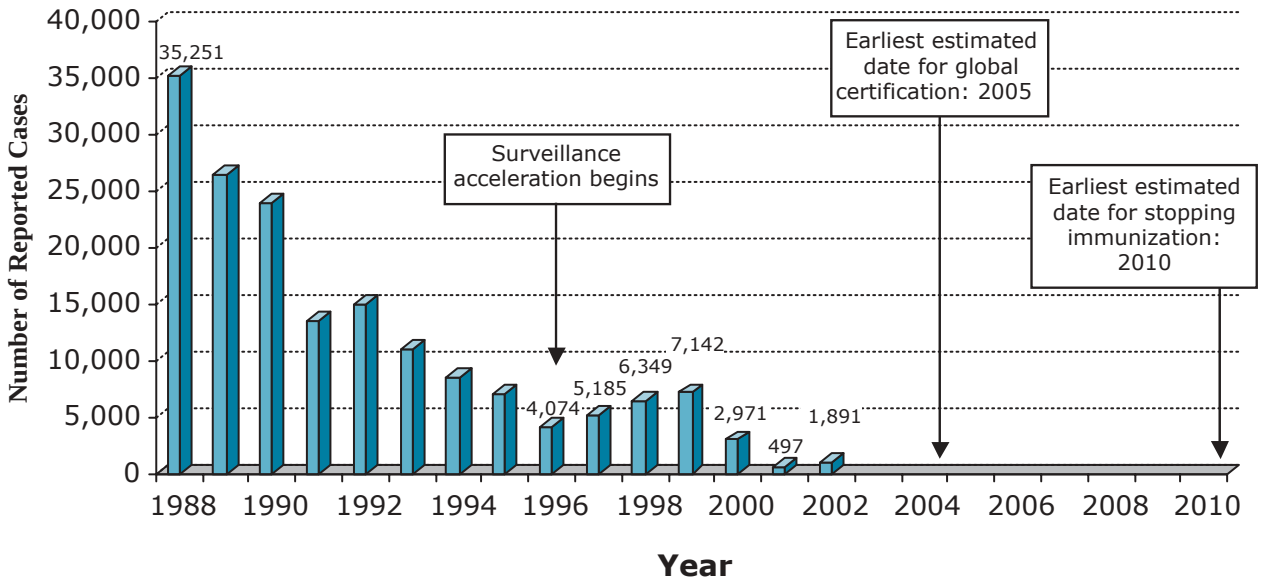


Photo by Franco, R.

Figure 2

Progress and Plan to Eradicate Polio



Source: World Health Organization. February 6, 2003.

USAID Strategy and Interventions

Through its Polio Eradication Initiative (PEI), USAID supports national immunization days (NIDs) and other special immunization campaigns that supplement and strengthen routine immunization services. Support includes assistance for advocacy, communications, social mobilization, microplanning, and the logistics of delivering oral polio vaccine under temperature-controlled conditions. The PEI assists with improvements in polio surveillance, laboratory accreditation, and research into the best ways for supplemental immunization campaigns to reach children in hard-to-reach populations or populations reluctant to accept immunization.

The PEI has six strategies within its newly revised results framework:

- Strengthening partnerships to mobilize resources and coordinate, plan, and implement activities
- Strengthening selected immunization systems at the national and subnational levels to achieve polio eradication, immunization, and other disease control goals
- Supporting supplemental immunizations
- Improving the quality of surveillance and response systems that are integrated with surveillance for other priority diseases
- Supporting certification, containment, and post-certification policy development at all levels
- Improving timely collection and use of information to continuously document the quality of polio eradication, routine immunizations, and diseases of public health importance

Key Achievements

Continued Progress Toward Interrupting Polio Transmission. Worldwide, polio transmission has been 99 percent interrupted. Two traditional poliovirus reservoir countries, Bangladesh and the Democratic Republic of the Congo, did not record any confirmed cases in 2001 or 2002 (although they are still high on USAID's "watch" list due to their proximity to polio-endemic areas). Most countries showed signifi-

cant declines, and only 10 polio-endemic countries remain. Five of these – Angola, Egypt, Ethiopia, Somalia, and Sudan – are low-transmission countries where polio transmission could be interrupted with continued political commitment and favorable social conditions.

Certification of European Region. In June 2002, WHO's European Region was certified polio-free after being free of indigenous poliovirus for more than three years under certification-standard surveillance. European countries continued to maintain high immunization coverage, surveillance, and response capacity in the event of imported cases.

Increased National Activities Throughout Africa. Synchronized multicountry NIDs in 20 West and Central African countries reached more than 96 million children in 2001 and 2002. In 2002, São Tomé and Príncipe joined the group of West African countries that synchronized NIDs. Subnational immunization days targeting children under age 5 were conducted mainly in countries of East and Southern Africa. In East Africa, Djibouti, Ethiopia, Sudan, Kenya, and Somalia participated in coordinated cross-border activities, with border districts sharing wild poliovirus and surveillance indicator data. These activities will continue and expand in 2003.

Private Voluntary Organizations Collaborating in India. In India, private voluntary organizations (PVOs) belonging to USAID's Child Survival Collaborations and Resources (CORE) Group helped the vaccination program in Uttar Pradesh state reach vulnerable Muslim families. At the request of the Ministry of Health, the PVOs and their local partners provided support

Outbreaks Highlight Need to Maintain High Immunization Coverage

A vaccine-derived polio outbreak occurred in Madagascar's Toliara Province in March and April 2002. USAID-supported surveillance activities detected a cluster of four cases of acute flaccid paralysis caused by circulating vaccine-derived poliovirus. Preliminary data indicated that the affected children had not been fully immunized.

In response, the global eradication campaign partners recommended that Madagascar conduct national immunization days in September and October 2002 using a "door-to-door" strategy to vaccinate all children under age 5. Further immunization days are planned for spring 2003.

USAID polio funds support supplementary immunization efforts such as these to ensure that all children complete the full series of polio immunizations. This outbreak of vaccine-derived poliovirus, as well as earlier ones in the Dominican Republic and Haiti, also reaffirms the need for the global eradication strategy to include:

- High polio immunization coverage in all countries until immunizations with oral polio vaccine cease
- Certification-standard surveillance of acute flaccid paralysis with genetic sequencing of all polioviruses
- Global consensus and coordination regarding the cessation of immunization once all regions are certified polio-free
- Laboratory containment of polioviruses once the disease is eradicated

Photo by Franco, R.

for social mobilization, marshalling volunteers to counsel Muslim families who were resisting immunizations for their children. In Calcutta, a local nongovernmental organization that partners with a CORE PVO was asked to cover slum wards because of its outstanding record of service. Due to the high-quality work performed by the organization's volunteers, the health department assigned them the task of cross-checking for missed children during follow-up efforts.

Intensified Efforts in South East Asia. WHO's South East Asia region, which includes the Indian subcontinent, accounted for almost 80 percent of the global total of polio cases in 2002. Across the region, USAID grants to WHO, UNICEF, CORE Group PVOs, and the International Clinical Epidemiology Network supported immunization programs, NIDs, and follow-up campaigns. USAID support also strengthened planning, surveillance, laboratory training, social mobilization, and information collection activities. USAID assisted country-specific activities in Bangladesh, India, Indonesia, and Nepal.

Looking Forward

USAID supports the World Health Assembly goal of global certification of polio eradication by 2005. To achieve this, all children must receive oral polio vaccine, an especially formidable task in areas of conflict. Increased community mobilization, use of vaccinators of appropriate gender or ethnic group, and activities to address misinformation about polio immunization will facilitate eliminating poliovirus from remaining pockets of transmission. Efforts to increase local government involvement and improve program administration need to be accelerated, and the political, financial, and program commitments to polio eradication must be maintained.

USAID strongly believes that significant improvements in routine immunizations are essential for:

- Interrupting wild poliovirus transmission in remaining endemic countries, particularly India, Nigeria, and Pakistan
- Avoiding outbreaks due to vaccine-derived poliovirus
- Sustaining and maintaining polio-free status
- Protecting the tremendous human and financial investments made thus far by individuals, organizations, and governments

Environmental sampling in Cairo, Mumbai, and West Bank/Gaza has demonstrated the presence of wild poliovirus in these areas even in the absence of reported polio cases. These findings have helped the eradication program caution governments against assuming polio has been eradicated and convince them there is a continuing risk of virus transmission and reintroduction of polio into their countries. The Democratic Republic of the Congo and Ethiopia, each with no reported cases in 2002, are other countries where surveillance and reporting of acute flaccid paralysis remain weak in areas that are difficult to reach. It is too soon for such countries to stop or cut back on supplemental immunization activities.

Planning for the post-certification era has already begun. The question of when it will be safe to stop polio immunizations is a major issue confronting the eradication campaign. USAID is working with the campaign partners

to support research, outline possible scenarios, and develop the most appropriate and effective timeframe and strategy for stopping polio immunizations. A key concern for USAID is to ensure that plans for supplemental immunizations and supplies of oral polio vaccine are connected to routine immunization coverage as the milestones for global certification are adjusted. USAID supports technical expertise and research to further address these issues.

In the long term, USAID sees its investment in polio eradication as a way to help build stronger systems for immunization and other disease control programs in developing countries.

Photo by IDRC/Marchand, D.

II. Child Survival and Maternal Health

Nutrition

Childhood malnutrition contributes to more than half of child deaths in developing countries. Inadequate breastfeeding and nutrient intake exacerbate childhood illnesses. Nutrition interventions such as breastfeeding and micronutrient supplementation can thus make substantial contibutions to decreases in child morbidity and mortality.

Breastfeeding is a proven means of providing infants with nutrients and protective antibodies. Breastfed infants are six times more likely to survive than non-breastfed infants, and a million children survive each year because of breastfeeding. Rates of diarrhea, respiratory tract infections, and other illnesses are all lower in breastfed than non-breastfed infants.

Micronutrient supplementation and food fortification programs can provide vitamin A, iron, iodine, and zinc to mothers and children whose diets are deficient in these micronutrients. Additionally, short-term food distribution and nutrition programs can prevent death and illness in emergency and crisis situations.

USAID Strategy and Interventions

USAID's program focuses on improving the nutrition of mothers, mothers-to-be, and infants and young children in conjunction with other key lifesaving interventions.

Appropriate infant feeding. Exclusive breastfeeding for the first six months of life is recognized as the optimal feeding practice to enhance child survival, growth, and development. Exclusive breastfeeding for six months has a strong protective effect against diarrhea by eliminating an infant's exposure to waterborne pathogens. It also provides protective antibodies against other diseases. Lactational amenorrhea (the absence of menses resulting from full breastfeeding during the first six months postpartum) can provide a woman with natural contraception while she breastfeeds her infant.

In developing countries, breastfeeding is recommended for up to two years. USAID provides technical assistance to health practitioners on how best to educate mothers about breastfeeding and child health. Complementary feeding – food properly introduced to a child around 6 months of age – is an important component of this education. USAID-supported interventions are tailored to specific cultural and regional practices.

Priority Nutrition-Related Objectives	Interventions
Reduced incidence of low birthweight among newborns	Improved antenatal care and maternal dietary practices
Improved growth and freedom from disease in early infancy	Promotion of early initiation of breastfeeding; exclusive breastfeeding for six months
Improved ability of children 6 to 59 months of age to fight infection	High-dose vitamin A supplementation; promotion of food fortification
Improved children's school performance	De-worming, micronutrient supplementation, food fortification to address anemia and iodine deficiency
Reduced incidence of anemia in women and children	Iron supplementation, food fortification in conjunction with anti-malaria/worm infestation interventions
Reduced incidence of iodine-deficiency disorders throughout the life cycle	Salt iodization
Reduced incidence of overall malnutrition	Use of available foods to improve diet; promotion of child feeding practices that provide a more diverse diet and greater consumption of available foods

Vitamin A Distribution and Child Health Weeks

Vitamin A is important for a healthy immune system, good vision, and reproduction. It is found in breast milk as well as meat, dairy products, eggs, and some fruits and vegetables. Children living in poverty, however, rarely consume sufficient quantities of these foods to protect their health and well-being.

Many countries now distribute high-dose vitamin A supplements to children 6 to 59 months of age. A number of countries where USAID had a strong role in establishing vitamin A supplementation now conduct their own high-coverage programs with little or no direct USAID assistance. These countries include Indonesia (72 percent coverage in 2002), Bangladesh (90 percent), the Philippines (76 percent), Nepal (96 percent), and Nicaragua (82 percent).

Many countries have been able to achieve high coverage by distributing vitamin A during polio national immunization days (NIDs). As polio eradication draws closer and NIDs are phased out, USAID and collaborating donor agencies are urging governments to establish programs to sustain high vitamin A coverage. During fiscal year 2002, Uganda and the Democratic Republic of the Congo conducted their first national vitamin A distributions, achieving coverage rates of 50 and 57 percent respectively. Of equal importance, there is strong evidence that mothers in countries with new supplementation programs are aware of and appreciate vitamin A and are willing to go twice a year to a central location to receive it. Zambia, Senegal, Morocco, and Ghana have taken advantage of this to establish "child health weeks" for delivering a package of preventive child health care services.

Reducing micronutrient deficiencies. USAID supports programs to relieve a wide variety of micronutrient deficiencies, including iron, vitamin A, and iodine deficiencies. Strategies include relatively inexpensive supplementation and fortification programs at both the community and national levels. USAID has been instrumental in the formation of the Global Alliance for Improved Nutrition (GAIN), a broad coalition of multilateral organizations, bilateral donors, foundations, and private sector industries dedicated to promoting food fortification as a means of reducing micronutrient deficiencies around the world.

Micronutrient research is an important source of new ideas and strategies for combating malnutrition and malnutrition-related disease and death. USAID has supported groundbreaking inquiries into the role of vitamin A in reducing maternal and child mortality and the importance of zinc as a micronutrient for disease prevention. USAID-supported Demographic and Health Surveys have been instrumental in identifying childhood anemia as a critical problem for the international community to address.

Food security and food aid. In times of chronic food shortage and especially of manmade or natural disasters that disrupt food production and distribution, USAID has a history of helping people in need. Food aid distribution also serves as a catalyst for improved health care delivery.

Key Achievements

- In **Madagascar**, exclusive breastfeeding promotion was incorporated into nutrition programs, reproductive health programs, and the Integrated Management of Childhood Illness initiative. As a result, exclusive breastfeeding

Controlling Anemia: The Way Forward

The World Health Organization estimates that globally as many as 5 billion people, or 80 percent of the world's population, could be iron-deficient. Iron-deficiency anemia – the most severe form of iron deficiency – affects more than 245 million children under 5 years old and up to 60 million pregnant women, the vast majority of whom live in developing countries. Iron deficiency has adverse effects on child development, and severe iron-deficiency anemia causes child and maternal deaths. The risk of maternal mortality increases 35 percent among pregnant women who have moderate anemia and by three and one-half times among pregnant women with severe anemia. Anemia also has significant effects on work productivity, household maintenance, child-raising activities, and social and economic development.

Malaria and hookworm infection are also important causes of anemia. Maternal malarial anemia causes low birthweight, preterm births, and up to 10,000 maternal deaths each year. More than 50 percent of children who die from malaria are anemic.

USAID anemia prevention campaigns increase awareness of iron deficiency and its consequences. This awareness is integrated into malaria control, de-worming, food fortification, and iron supplementation efforts. USAID also supports efforts to determine anemia prevalence, implement monitoring systems, and develop and implement treatment protocols for severe anemia in malaria-endemic areas.

increased from 46 percent in January 2000 to 71 percent by the end of 2001. The greatest improvements were observed for 4- to 5-month-olds, indicating the willingness of mothers to sustain exclusive breastfeeding through the recommended six-month period.

- To reduce the risk of transmitting HIV infection through breast milk, USAID-supported partners in **Zambia** collaborate with district health management teams and other local partners in clinic- and community-based maternal and child health services. Trained counselors provide mothers with information so they can weigh the risks and benefits of different feeding options and choose the safest strategy for their situation. Mixed feeding of breast milk and other liquids or foods during the infant's first six months (which carries the highest risk of HIV transmission) declined in the program area, while exclusive breastfeeding of infants less than 6 months old increased from 57 to 69 percent. Initiation of breastfeeding in the first hour after birth increased from 59 to 83 percent.
- In areas with high vitamin A deficiency and in areas where under-five mortality exceeds 75 deaths per 1,000 live births, vitamin A distribution can reduce mortality in children 6 to 59 months of age by an estimated 23 percent. In **Indonesia**, where in 1999 vitamin A coverage among preschool children was far below the target of 80 percent, USAID has supported stepped-up vitamin A distribution through technical assistance, training, multimedia campaigns, studies, and surveys. Coverage has increased from 41 to 70 percent among infants 6 to 12 months old, from 65 to 73 percent among 1- to 5-year-olds, and from 29 to 72 percent among vulnerable urban infants. The program saved the lives of an estimated 35,000 children under age 5 in 2001.
- Since 1999, USAID and other partners in **Senegal** have helped the Ministry of Health organize "micronutrient days" and vitamin A supplementation during polio national immunization days (NIDs) to ensure that at least 80 percent of children 6 to 59 months of age receive high doses of vitamin A every six

Photo by USAID/Jordan, S.

months. Vitamin A coverage during NIDs was 93 percent nationwide and 95 percent in 15 project districts.

- In **Tanzania**, a randomized trial demonstrated improved language development among preschool children following 12 months of iron supplementation. Moderately anemic children showed improved motor skills. Such findings highlight the importance of preventing iron deficiency and anemia in young children.
- After two years of drought and continuing economic difficulties, **Tajikistan** began receiving emergency relief from the World Food Programme. USAID assists with support for basic health education, nutrition monitoring, and appropriate micronutrient supplementation. Out of 19,000 children monitored, 1,474 were diagnosed as moderately malnourished and registered to receive supplementary foods. Another 171 severely malnourished children were referred for treatment at therapeutic feeding centers in hospitals. Almost 5,000 women attended nurse-led education sessions on how to decide about breastfeeding and introducing solid foods for their babies.
- In response to **Georgia's** worst drought in 50 years, USAID worked with the government and other partners to provide seed and special credit packages to almost 38,000 households. More than 800 agricultural loans were provided, and over 10,000 hectares of crop land planted. USAID's quick response prompted other international donors to join the relief effort. Due in part to the quality of seed provided, the first post-drought harvest was more than twice as large as pre-drought harvests.
- In **India**, USAID supports the government's Integrated Child Development Scheme in eight states. The program integrates the Title II food aid program with ancillary maternal/child health services, reaching approximately 7.3 million poor women and children in over 100,000 villages. Between 1997 and 2001, iron-folate supplementation rates for pregnant women increased from 13 to 37 percent; timely complementary feeding rates for infants improved from 46 to 67 percent; and supplementary feeding coverage of children under age 2 rose from 40 to 64 percent. The "take-home ration" strategy was successful in improving coverage rates in the priority target groups of children under 3 and pregnant and nursing mothers.

Acute Respiratory Infections, Control of Diarrheal Diseases, and Integrated Management of Childhood Illness

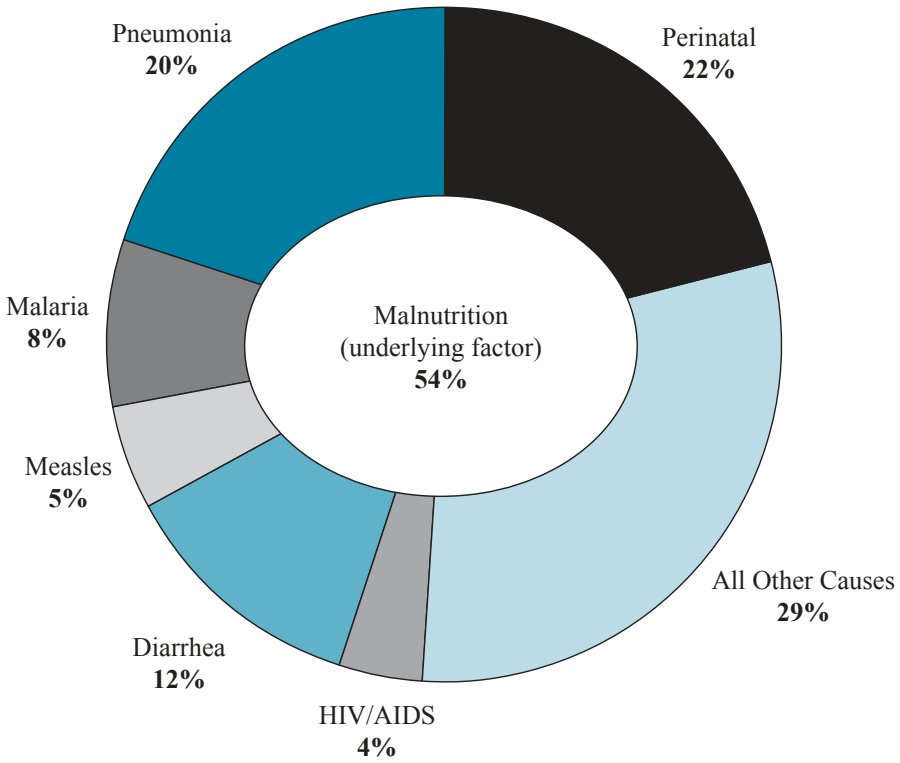
Acute respiratory infections, especially pneumonia, and diarrheal diseases are responsible for about one-third of deaths among children under age 5. USAID is committed to combating these major causes of child mortality through the continuing development and introduction of effective technologies and approaches. The Integrated Management of Childhood Illness approach combines interventions for preventing and treating the biggest killers of children under age 5, including acute respiratory infections, diarrhea, malaria, malnutrition, and measles. USAID supports the expansion of this approach at the community and household levels.

USAID Strategy and Interventions

Acute respiratory infections (ARI). Pneumonia is responsible for one-fifth of all child deaths. Worldwide, respiratory infections are the cause of 30 to 40 percent of pediatric visits to health facilities. Standard case management procedures,

Figure 3

Proportional World Mortality Among Children Under Age 5, 2000



Source: Evidence and Information for Policy/WHO Child and Adolescent Health and Development, 2002.

Online: www.who.int/child-adolescent-health/integr.htm

Community-Based Management of Child Pneumonia

Upon USAID's initiative, 34 representatives from research institutions, national health care programs, and international agencies met in Stockholm in June 2002 to review research and program findings about community management of acute respiratory infections. The findings included the results of a USAID-supported meta-analysis, which showed that community-based trials of pneumonia case management had reduced child mortality by 26 percent and mortality from pneumonia by 33 percent. Most of this impact was due to the use of community health workers to diagnose, treat, and refer cases.

The meeting participants reached consensus on issues with important implications for future ARI programming. They concurred that:

- Trained and supervised community health workers and volunteers are capable of diagnosing children with pneumonia and treating them with antibiotics. Programs in Honduras, Nepal, and Pakistan have found these workers and volunteers can significantly affect under-five mortality.
- Having community health workers provide antibiotics is more effective than referring cases to the nearest health facility. Allowing these workers to perform this function is an important policy issue. Where malaria is a major killer of children, the most effective strategy may be to link pneumonia treatment with malaria control programs. With proper controls, community health workers should have authority to dispense both antibiotics and antimalarial drugs.

including appropriate ARI recognition and proper use of simple and cheap antibiotics, could avert 30 to 60 percent of ARI-related child deaths. Such treatment is not available, however, to many children in countries with low health system coverage. USAID programs in countries such as Honduras and Nepal have shown that with good training and a regular supply of antibiotics, community health workers can identify and treat children with pneumonia. Accordingly, USAID is working with UNICEF and WHO to increase the availability of such community treatment in some of the poorest countries.

Achieving a major impact on ARI-related mortality requires timely recognition of ARI and its symptoms by mothers and other caregivers as well as improved access to care. Comprehensive immunization against *Haemophilus influenzae* type b and high DPT3 and measles vaccination coverage are also important for preventing ARI deaths in children. Current USAID programs and research activities focus on ARI prevention and care through improved nutrition, breastfeeding, and immunizations; reduced indoor air pollution; early ARI recognition; improved home management; appropriate management by primary and community health care workers; and rapid referral of the most serious cases. Because pneumonia treatment requires antibiotics, several USAID-supported programs also promote the availability of effective antibiotics.

Diarrheal diseases. At the 1990 World Summit for Children, nations from around the world agreed upon several child survival and health goals for the decade. In 2002, these nations came together and took stock of their progress. A 50 percent reduction in deaths due to diarrhea was one of the few goals realized. While this achievement equates to 1 million fewer children dying annually from diarrhea than in the early 1990s, diarrhea nonetheless remains a leading cause of under-five mortality worldwide.

Since the 1960s, USAID has been instrumental in developing, introducing, and expanding the use of oral rehydration salts (ORS) and oral rehydration therapy (ORT, which combines ORS with breastfeeding in infants and with fluids and supplemental feeding in older children) to combat diarrhea-related dehydration. The 1990s saw dramatic progress in home management of child diarrhea. In 33 countries containing almost half of the world's under-five population, use of ORS or recommended home fluids increased from about one-third of cases in 1990 to 85 percent of cases by mid-decade.

USAID programs are seeking further reductions in diarrhea-related illness and death through continued expansion of ORT coverage to unreached populations and continued promotion of adequate care and timely care-seeking at the community level. Breastfeeding, improved water supplies and sanitation, and continued feeding of children with diarrhea are also integral components of USAID's strategy to reduce diarrheal diseases and their effects. In addition, USAID supports zinc supplementation as a simple inexpensive intervention that can decrease the duration and severity of diarrheal disease in children under age 5. Studies have demonstrated that a 7- to 10-day course of 20-mg zinc supplements can reduce diarrhea severity by 40 percent and its duration by 20 percent, as well as reduce future occurrences. Zinc is also part of USAID-supported food fortification initiatives.

Integrated Management of Child Illness (IMCI). USAID continues to support IMCI as a complementary approach to other family and child health interventions. Since its inception in the 1990s, IMCI has evolved into a broad strategy encompassing the components of improved health worker skills, strengthened health systems, and improved household and community practices related to health and nutrition.

Photo by USAID/Destler, H.

USAID activities are increasingly directed toward IMCI's household and community component. Community IMCI studies supported by USAID indicate that many children who die from preventable causes never receive care from public health services. These deaths are associated with inadequate family recognition of life-threatening illness and inadequate knowledge of appropriate home care. In addition, lack of access to adequate treatment often drives families to ineffective or substandard sources of care. These findings have increased the interest in families and communities as key focal points for achieving additional progress in child survival.

USAID is also participating in a WHO-led review of the IMCI strategy, including both its health systems and household/community components. The review aims to define IMCI's possible contributions to meeting children's needs for improved health and development. It will also consider refined program and investment strategies for achieving greater impacts on child health. The review's final analyses are expected early in 2003.

Key Achievements

- USAID is supporting a multicountry study to identify improved treatment strategies for non-severe, severe, and very severe pneumonia. The study aims to improve treatments, lower costs, and control the spread of antimicrobial resistance to antibiotics. A recently completed eight-country study has demon-

Photo provided by BASICS

strated that severe childhood pneumonia can be treated with oral amoxycillin instead of injectable penicillin at less cost and with fewer associated risks. The findings will be incorporated into WHO guidelines.

- In **Nepal**, where USAID assistance has contributed to a 42 percent decline in under-five mortality in the past 15 years, female community health volunteers are being trained to identify children with pneumonia and treat them with an inexpensive antibiotic sold to mothers at cost. The mothers pay only 23 cents, while the average cost of treatment from other sources is more than $3.20. With seven new districts added in the past year, the program now operates in 21 districts. Over 125,000 cases of pneumonia are now treated at the community level in program districts each year, with greatly reduced death rates.
- WHO introduced an improved ORS formula at the 2002 United Nations General Assembly Special Session on Children. The formula, developed after extensive USAID-supported research, reduces the severity and duration of acute diarrheal illness. It should reduce the need for intravenous fluids by 33 percent and result in fewer diarrhea-related hospitalizations. WHO estimates that the new formula could avert 14,000 deaths and save $7.1 million for every 1 million diarrhea episodes.
- A group of international donor organizations, including the World Bank, UNICEF, and USAID, have joined with multinational and national soap manufacturers in **Ghana**, **India**, **Nepal**, **Peru**, and **Senegal** to launch public-private partnerships to promote hand washing with soap. The campaign is modeled after a successful USAID-led initiative in five Central American countries that in the late 1990s produced 50 percent increases in hand washing with soap among mothers and reduced diarrheal diseases in children under age 5 while obtaining significant resources from public and private sources.
- After Hurricane Georges struck the **Dominican Republic** in September 1998, USAID brought together the government's rural water authority and nongovernmental organizations to rebuild infrastructure and improve hygiene behaviors to prevent diarrhea in affected communities. After five months, an assessment in pilot communities showed that the percentage of households storing water appropriately had increased from 41 to 92 percent and that hand washing with soap and access to hygienic latrines had also increased substantially. These activities have since expanded from localized partnerships into a national initiative. In addition, **Nicaragua** and **Peru** are introducing a hygiene program guide from the Dominican Republic into their IMCI programs.
- USAID has been supporting efforts to improve health worker performance in treating major childhood illnesses in Ouémé Province in southeastern **Benin**. Health facility surveys have found that six months after receiving IMCI training, nearly all workers were weighing children (up from 39 percent in 1999), 90 percent were correctly treating children with malaria (up from 60 percent), and 73 percent were correctly treating children with pneumonia (up from 28 percent).

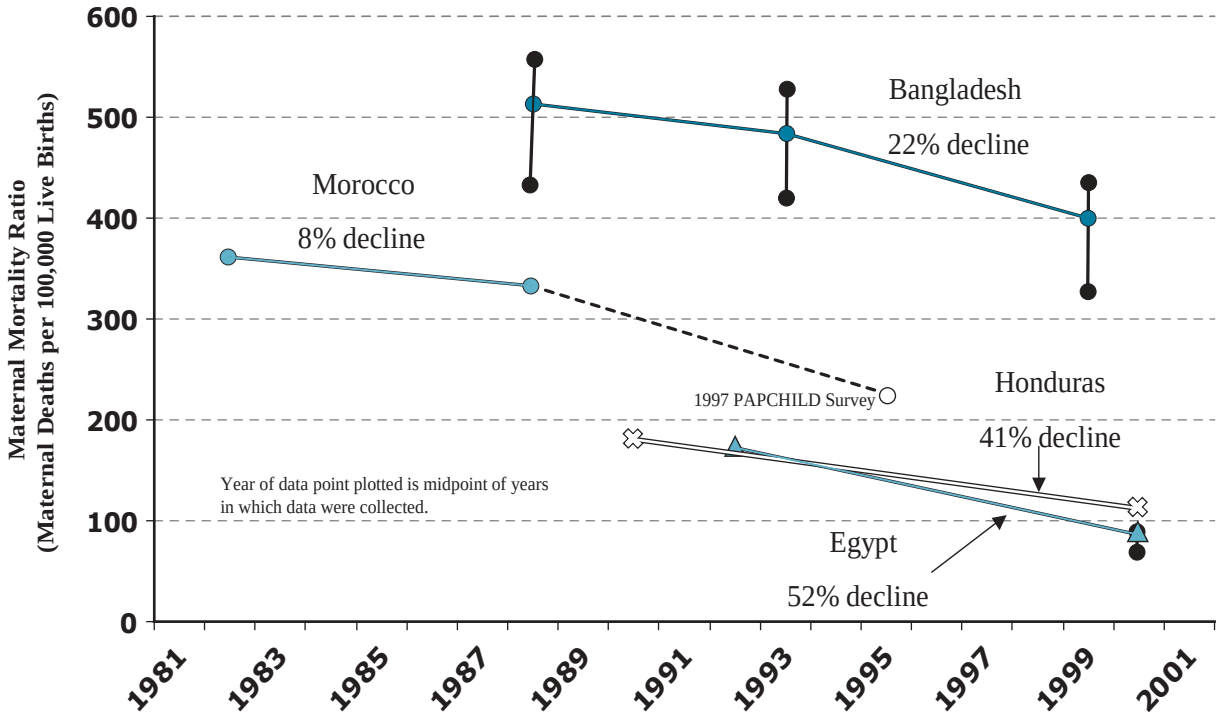
Maternal and Neonatal Health

While maternal mortality remains high throughout the developing world, a number of USAID-assisted countries have achieved significant reductions in maternal deaths from pregnancy-related causes. In Egypt, for example, maternal mortality has declined by 52 percent since the late 1980s. Honduras (41 percent), Bangladesh (22 percent), and Morocco (8 percent) have also had substantial decreases. Sub-Saharan Africa is not sharing in such successes, however. Most countries in the region have had little or no reduction in maternal mortality in the last decade, and recent Demographic and Health Surveys indicate that Zimbabwe and Malawi have experienced increases. Sub-Saharan Africa's HIV/AIDS epidemic likely contributes to these trends.

Maternal health and nutrition profoundly affect newborn survival and health, and regional trends in neonatal mortality (death during the first 28 days of life) parallel trends in maternal

Figure 4

Successes in Maternal Mortality Reduction Selected USAID Countries



Note: Vertical bars indicate 95 percent confidence intervals.
Sources:
Morocco: DHS data from Measure Evaluation. 2002. "Morocco, 30 Years of Collaboration Between USAID and the Ministry of Health."
Bangladesh: National Institute of Population Research and Training. 2002. "Bangladesh Maternal Health Services and Maternal Mortality Survey," 2001. Preliminary Report.
Egypt: Egypt Ministry of Health and Population. 2001. "Egypt National Maternal Mortality Study 2000."

mortality. While countries in USAID's Asia/Near East region (including Bangladesh, Egypt, Indonesia, Nepal, and Turkey) and Latin America/Caribbean region (Bolivia, Brazil, Guatemala, and Paraguay) have seen declines in neonatal mortality, increases have been documented in the sub-Saharan African countries of Burundi, Ivory Coast, Kenya, Niger, Rwanda, Tanzania, and Uganda.

Research advances in maternal health and mortality have enabled USAID to identify successful programs and apply their lessons in countries in need. While specific interventions vary from country to country, policy development, community involvement, and improved service delivery are common denominators. Improved quality of obstetric care, community education about obstetric and newborn complications, prompt medical care for complications, and increased access to family planning are major contributors to maternal and neonatal survival and health. With political and financial commitment, programs have been able to achieve significant successes in a relatively short time.

Photo by USAID/Destler, H.

USAID Strategy and Interventions

USAID's approach to maternal and neonatal health includes community involvement, the promotion of evidence-based policies, and compassionate high-quality services. USAID's approach focuses on reducing preventable maternal mortality by equipping birth attendants – both home attendants and attendants in health centers and hospitals – with the skills, drugs, and supplies to deliver lifesaving care. Skilled attendants are essential for recognizing and treating unpredictable maternal and newborn complications. USAID also promotes good nutrition and control of infectious diseases to improve pregnancy outcomes.

USAID supports quality health services delivered by medically trained birth attendants. These services target vulnerable, high-mortality populations in areas with weak health services but a strong commitment to improving maternal and neonatal health. Programs prepare communities for births by helping them improve maternal care, recognize complications, and make transportation and payment arrangements. USAID helps policymakers develop practical evidence-based care standards and develop quality assurance systems to ensure satisfaction and positive results. Key evidence-based interventions emphasize:

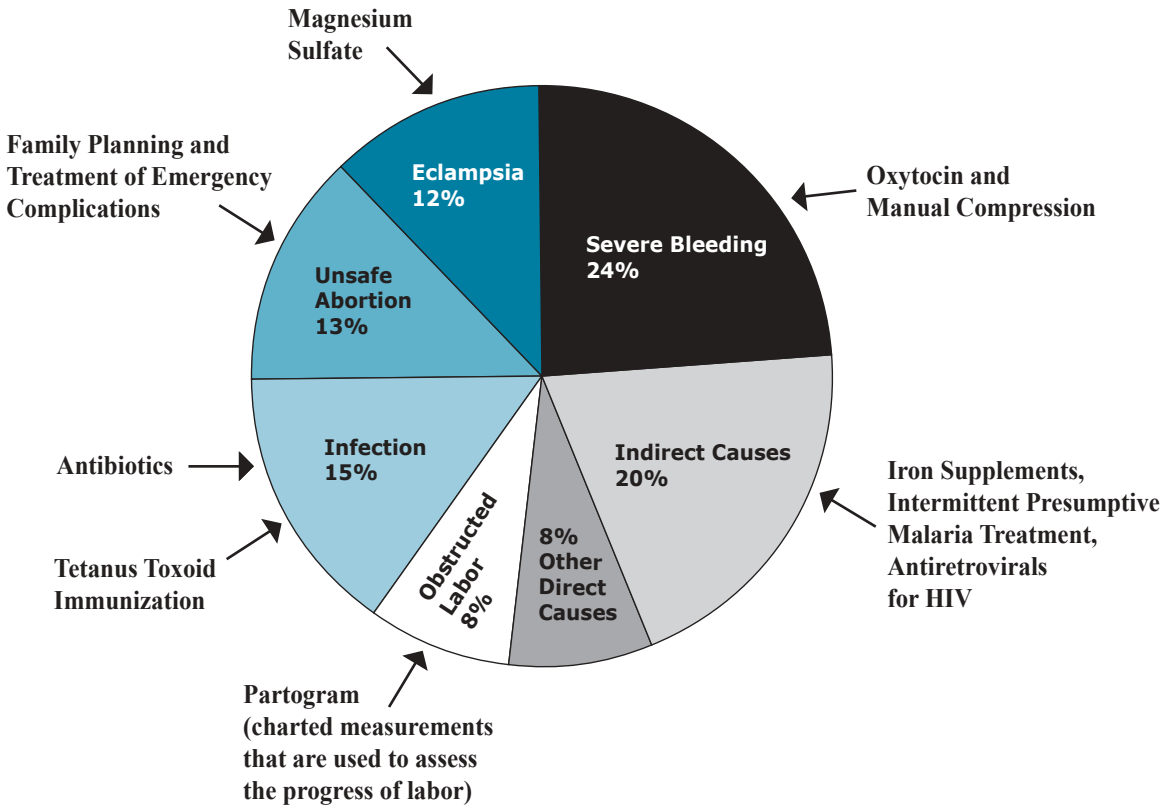
- Iron-folate supplementation
- Tetanus toxoid immunizations
- Syphilis control
- Intermittent presumptive malaria treatment and use of bednets for malaria prevention
- Prevention of mother-to-child transmission of HIV
- Counseling on safe health practices and birth planning
- Safe, clean delivery
- Treatment of obstetric and newborn complications
- Early, exclusive breastfeeding and birth spacing

Key Achievements

Reducing Perinatal Mortality in South Africa. As part of a province-wide quality assurance effort, four hospitals in Mpumalanga Province,

Figure 5

Maternal Mortality is Preventable: Evidence-Based Interventions



**Other direct causes include ectopic pregnancy, embolism, anesthesia-related problems.*
***Indirect causes include anemia, malaria, heart disease.*
Source: "Maternal Health Around the World." World Health Organization, Geneva, 1997.

South Africa, have focused on decreasing perinatal mortality. In each hospital, a quality improvement team identified performance gaps in newborn care and developed solutions. One hospital developed guidelines for managing newborn asphyxia, hypothermia, and hypoglycemia, and implemented on-the-job training to improve provider knowledge. During 2000 and 2001, compliance at the hospital with newborn screening examinations increased from 20 to 90 percent. Regular monitoring of women in labor and newborns also steadily increased. In 2001, neonatal mortality at the hospital decreased from more than 30 deaths per 1,000 live births to less than 15, while stillbirths decreased from 20 per 1,000 births to less than 10.

Reduced Maternal and Neonatal Deaths in Bolivia. As part of Bolivia's participation in the Latin American Maternal Mortality Initiative, USAID helped the Ministry of Health and local nongovernmental organizations increase the quality and use of essential obstetric care at health facilities. The program helped families, leaders, and community health workers strengthen clinical services, promote supportive maternal health policies, and develop community transportation and payment plans for obstetric care. In Ichilo district, maternal deaths fell from

5 in 1999 to 1 in 2001. There was also a sustained reduction in hospital neonatal mortality from 2 percent to less than 1 percent between March 2000 and September 2001.

Sustaining Improvements in Neonatal Respiratory Distress Syndrome in Russia. In 1997, respiratory distress syndrome was a leading cause of newborn mortality in Tver *oblast*, Russia, causing 66 percent of premature newborn mortality. Beginning in late 1998, USAID provided technical assistance to redesign all aspects of neonatal care, including evidence-based clinical guidelines, a new health transportation system, a new central neonatal referral unit, and neonatal resuscitation training for pediatricians, obstetricians, midwives, and nurses. By the end of 2001, 95 percent of neonates with respiratory distress syndrome were surviving at least seven days after initial resuscitation. The incidence of hypothermia on arrival at the neonatal intensive care unit had fallen from 63 percent to occasional rare exceptions, and the unit had achieved a 64 percent reduction in deaths due to respiratory distress syndrome.

Bangladesh's "Reducing Maternal Mortality" Program. In Bangladesh, lack of awareness and information about pregnancy danger signs and the need to seek emergency obstetric care contributes to high maternal mortality. In response, USAID has supported the "Reducing Maternal Mortality" program. The program uses mass media and community-based training to teach pregnant women and their families how to identify pregnancy complications and seek care for obstetric emergencies. The program contributed to an 11 percent increase in use of antenatal care services at health facilities and a 42 percent increase in hospital deliveries in 17 program communities between 2000 and 2001. To prepare for complications, many communities have compiled lists of blood donors, raised funds for transport to essential obstetric care, and arranged transport.

Photo by Gilbert, L.

Improving Emergency Obstetric Preparedness in Guatemala. USAID works with the Ministry of Health in Guatemala to increase the adoption of standard maternal and neonatal survival practices. In 2002, 190 providers from 54 facilities in eight health areas (covering approximately 30 percent of Guatemala's women of reproductive age) were trained using international evidence-based standards and guidelines developed with USAID support. Between January and September 2002, obstetric services in program areas met 60 percent of the need, compared with 55 percent for the same period in 2001.

Midwife Training in Afghanistan. Educational programs for midwives in Afghanistan were closed under the Taliban. As a result, there are few female health care workers to care for women during delivery and in obstetric emergencies. With USAID support, the training program for midwives has reopened. A new training program for auxiliary midwives has also been initiated. Training curricula have been developed and training sites upgraded with equipment, water and sanitation, and essential supplies. In June 2003, the first classes of midwives and auxiliary midwives will graduate.

Reducing Maternal Mortality in Egypt. The maternal mortality ratio in Egypt declined dramatically during the 1990s from 174 maternal deaths per 100,000 live births in 1992/93 to 84 maternal deaths per 100,000 live births in

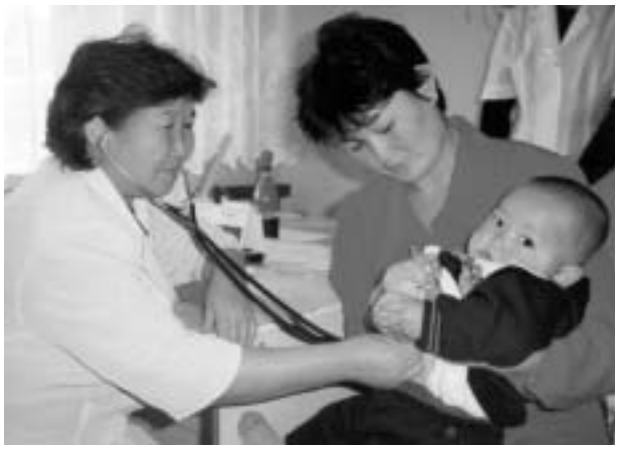


Photo by USAID/Destler, H.

2000/01. Upper Egypt, the poorest area in the country, experienced greater improvements in maternal mortality than the more affluent Lower Egypt. The dramatic improvements are a result of Egypt's efforts, with USAID assistance, to improve access to high-quality prenatal and delivery care, family planning, and education for girls.

Looking Forward

Data from around the world show that bleeding after childbirth, or postpartum hemorrhage, is the greatest cause of maternal mortality. In response, USAID will launch a special initiative to spotlight prevention of postpartum hemorrhage in the context of maternal and neonatal health services. Programs are being designed and funds directed to initiate programs in Benin, Ethiopia, Mali, and Zambia. The initiative will address the critical issues of scientific standards of care and the availability of essential drugs and supplies.

USAID has also recently joined the Initiative for Maternal Mortality Programme Assessment, an alliance of donors and multilateral agencies formed to strengthen the evidence base for reducing maternal mortality and severe morbidity. It will bring together a large group of skilled researchers to identify the most effective and cost-effective approaches to improving pregnancy outcomes in resource-poor environments.

III. Family Planning and Reproductive Health

Photo by USAID/Destler, H.

III. Family Planning and Reproductive Health

Photo by Rigby, H.

For more than 35 years, USAID has been a world leader in supporting family planning and reproductive health programs in developing countries. By helping couples decide how many children they want and the timing of the mother's pregnancies, family planning and reproductive health programs have contributed to 25 percent decreases in maternal and infant deaths. Through field-driven program design, comprehensive technical support, timely and authoritative research, global leadership, and high-impact partnerships, USAID has played a critical role in helping families achieve their desired family size while protecting the health of women and children.

USAID Strategy and Interventions

USAID's family planning and reproductive health programs use a client-centered approach that emphasizes informed choice and works to increase the availability and voluntary use of family planning services. USAID's strategy supports the purchase and supply of contraceptives and related materials, access to family planning information and services, and the integration of family planning information and services into other health activities.

USAID's family planning and reproductive health programs support the following objectives:

- Increasing the number of women and men who can freely and responsibly determine the number and spacing of their children by maximizing access to and improving the quality of family planning
- Reducing unintended pregnancies and promoting maternal and child health
- Reducing and stabilizing population growth rates in countries where that is a national priority

Access to services. USAID programs have achieved widespread local access to family planning services through community-based distribution of commodities, workplace programs, and social marketing of contraceptives through retail outlets. Experience has shown that increasing choice of methods increases use of family planning. Therefore, USAID programs provide access to a wide variety of family planning methods, including modern natural methods.

Improving health care through training. USAID has supported training for thousands of physicians, nurses, midwives, community health workers, and traditional birth attendants. USAID programs develop training systems to improve provider performance. USAID also provides assistance for analyzing system and human resource deficiencies, introducing new supervisory methods and standards, developing management and leadership skills, and building capacity in both the public and private sectors.

Communication and education to promote healthy behaviors. Innovative communication programs are a critical component of USAID's family planning and reproductive health activities. USAID-supported communication pro-

Comprehensive Programs and Country-Level Results

USAID's family planning and reproductive health program in **Malawi** focuses on training, service provision, logistics, management, and diagnosis and treatment of sexually transmitted infections. Although its total fertility rate is among the highest in the world, Malawi has made significant progress in increasing contraceptive prevalence and reducing fertility. The total fertility rate has dropped from 6.7 births per woman in 1992 to 6.3 births in 2000. A principal cause of this decline has been the steady increase in contraceptive use over the last decade. Since 1992, the contraceptive prevalence rate among married women has more than tripled from 7 to 26 percent.

Between 1994 and 1999, USAID provided access to modern family planning information and services to more than 4 million women in **Russia**. Survey data show that abortion rates steadily declined and modern contraceptive use increased in project areas while remaining relatively constant at control sites. National data indicate that abortion rates in Russia declined significantly over the last decade, from 114 per 1,000 women of reproductive age in 1990 to 55 in 2000. Since 1999, USAID has pursued a broader maternal and infant health program that includes high-quality family-centered maternity care and family planning counseling and services for post-abortion and postpartum women. This program has trained more than 500 health professionals in such areas as maternal and neonatal care, family planning, and exclusive breastfeeding. These providers have in turn provided local training to an additional 3,788 providers.

Recent surveys have shown a significant increase in modern contraceptive use among women in USAID-assisted countries that once lagged far behind global averages. In 2002 in **Zambia**, for example, the Demographic and Health Survey reported 22.6 percent use of modern contraceptive methods among married women, an increase from 14.4 percent in 1996. **Uganda** has reported a more than twofold increase in modern contraceptive use, from 7.8 percent in 1995 to 18.2 percent in 2001. USAID-supported activities in these countries have included social marketing, training, commodities and logistics support, and technical assistance to improve service quality, technical competence, and counseling.

grams influence key behaviors, such as delay of sexual activity by youth, as well as social norms and policies.

Social marketing. Social marketing has evolved into one of the most successful of USAID's family planning-related activities. Social marketing uses the commercial sector to deliver high-quality affordable products and services to lower-income consumers.

Contraceptive supplies. USAID's logistics supply system prevents stock-outs of contraceptive methods, assists other donors, and helps ensure the long-term availability of a range of methods and other essential health supplies to clients.

Quality of care. Improvements in client-provider interactions, such as courteous client-tailored counseling, clear information about contraceptive methods (including their proper use and common side effects), and respect for the client's choice of method, result in more and better contraceptive use. USAID's programs emphasize improved communication and technical competence, strengthened program manage-

Photo by IDRC/Dupois, C.

ment and supervision, and policy changes to improve quality.

Integrating health services. Given the scope and consequences of the HIV/AIDS pandemic, integrating family planning into HIV/AIDS and sexually transmitted infection services, and vice versa, is crucial. Most family planning programs can undertake primary prevention activities, particularly counseling and providing condoms and other barrier methods of contraception. USAID is supporting a study of the acceptability and feasibility of incorporating family planning services into HIV voluntary counseling and testing services.

Leadership for supportive policy environments. USAID programs have worked with national governments and other donor agencies to improve planning and financing for family planning and reproductive health. To ensure that policy decisions are made on the basis of accurate, up-to-date, and relevant information, USAID helps developing countries manage census counts, conduct surveys, and carry out policy analyses, strategic planning, and program evaluation. USAID also seeks to increase non-USAID resources for family planning and reproductive health and to foster more efficient use of host-country funds to ensure long-term program sustainability.

Research. USAID supports research to expand the range and availability of safe, effective, acceptable technologies for preventing unintended pregnancies, sexually transmitted infections, and HIV. Areas of activity include improvements in natural family planning methods and the development of barrier methods of contraception, long-acting hormonal contraception for women and men, and improved delivery systems. Additional information on USAID's research activities can be found in chapter VII of this report.

Key Achievements

- In **Egypt**, USAID helped Egypt's 14 medical schools update their family planning and reproductive health curricula. Culturally sensitive and specific to Egypt, the new curricula include modules on family planning methods, sexually transmitted infections, female genital cutting, infertility, menopause, hormone replacement therapy, and screening and early detection of reproductive tract malignancies. The family planning module was the first to be approved by the national curriculum coordination committee and introduced into the medical schools.
- Family planning and reproductive health services in **Ethiopia** are expanding from urban and peri-urban areas to more rural areas through the use of community-based agents in markets, factories, and farms. This expansion is providing people with more access to family planning methods. The social marketing program sold more than 815,000 oral contraceptive cycles in 2002.
- In **Ghana**, USAID worked with the Ministry of Health to strengthen preservice midwifery education in the country's 12 midwifery schools. The program introduced a standardized competency-based curriculum guide, reinforced faculty and clinical preceptor skills, and strengthened clinical training sites. In May 2002, USAID supported a case-control study comparing the knowledge and skills of midwives who graduated from schools with the program

and the knowledge and skills of midwives who graduated from schools without the program. The trained midwives scored significantly higher in overall knowledge and performance of most skills.

- In **Senegal**, nearly one in five women requiring emergency obstetric care has had a non-medical abortion. USAID supported improved emergency treatment for women with complications from miscarriage or abortion through the introduction of new clinical techniques at three hospitals. Providing women with improved post-abortion care services resulted in shorter hospital stays, decreased patient costs, better provider-patient communication, and increased acceptance of later contraceptive use. After the intervention, the proportion of patients receiving family planning counseling doubled. Of those who were counseled, the proportion deciding to use a contraceptive method increased from 56 to 76 percent.
- Between 1998 and 2002, a USAID-funded consortium of agencies in **Egypt** conducted a training and affiliation program for private sector pharmacists and physicians. The project involved 55 percent of all private pharmacists through a program of quarterly visits and promoted their services through point-of-sale information materials and an "Ask and Consult" logo. The project also promoted new hormonal contraceptive methods available in the private sector. The project significantly increased knowledge and choice of family planning methods as well as private sector demand for hormonal contraceptives. Women's knowledge of progestin-only pills increased from 45 percent in 2000 to 80 percent in 2002, and 75 percent of women had heard of monthly injectable contraception. Private sector sales of all categories of hormonal contraceptives increased by 41 percent from 1996 to 2001.
- Last year, **Turkey's** family planning and reproductive health program "graduated" from USAID support and became self-sustaining. To achieve a successful transition and sustain program gains, close-out priorities focused on establishing self-reliant public sector family planning services, expanding post-abortion care and postpartum family planning services, institutionalizing voluntary sterilization, and establishing sustainable reproductive health systems. Family planning and reproductive health training was standardized in 17 medical and 19 midwifery schools. The Ministry of Health institutionalized in-service training systems.
- USAID-sponsored research shows that three- to five-year birth intervals benefit both mothers and children. To disseminate the recommendation that **"Three to Five Saves Lives,"** USAID sponsored an international conference in October 2002 for 88 participants from 13 countries. Two regional and six country-specific plans were developed to strengthen and scale up birth spacing programming. As a result of the conference, Guatemala's Ministry of Health requested that a similar conference be held for the

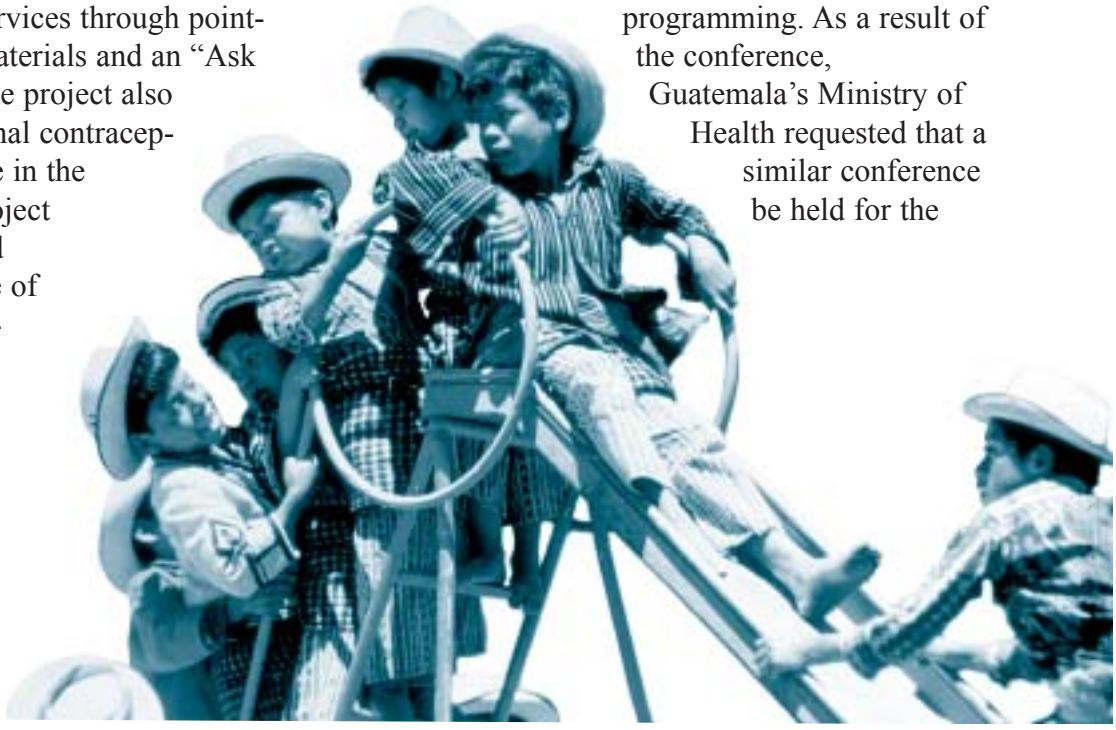


Photo by UNICEF/Ibrahim, K.

health ministries of seven Central American countries. Additionally, focus group research in Bolivia, India, Pakistan, and Peru has shown that providers have virtually no technical guidance or standards regarding birth spacing and thus seldom counsel clients on this topic. The research results will be used to develop provider training programs and counseling modules.

- USAID-supported research on female genital cutting in **Burkina Faso** and **Mali** showed that women who have experienced this practice have, in addition to the physical and psychological trauma of the cutting itself, increased risks of gynecologic and obstetric problems, including complications during childbirth. The study concluded that health personnel should receive information on the serious health problems associated with female genital cutting and that personnel who assist women in labor should anticipate the possibility of complications. Mali's Ministry of Health is using the study results to develop a curriculum that promotes standardized mandatory training for all health providers on the health problems associated with female genital cutting.

Photo by Fisch, A.

Looking Forward

In the coming year, USAID family planning and reproductive health programs will focus on improved contraceptive security and on closing the gap between demand for and access to contraceptives. Underserved groups such as men, youth, and rural populations will receive special attention. Young people will continue to be an important target group for reproductive health programs because of the size of youth populations in developing countries and their importance to future development. USAID programs for youth aim to delay sexual activity and first pregnancy and increase responsible behavior, including abstinence, partner reduction, and condom use. Activities will also seek to raise awareness of the importance of family planning programs in light of the HIV/AIDS epidemic, particularly in Africa, and continue efforts to improve the integration of reproductive health and HIV/AIDS efforts. In addition, USAID will examine how reproductive health issues can be incorporated into poverty alleviation programs. Efforts to strengthen the integration of population, health, and environmental programming will give special attention to monitoring and evaluating integrated activities.

IV. HIV/AIDS

Photo by Marchewka, R.

IV. HIV/AIDS

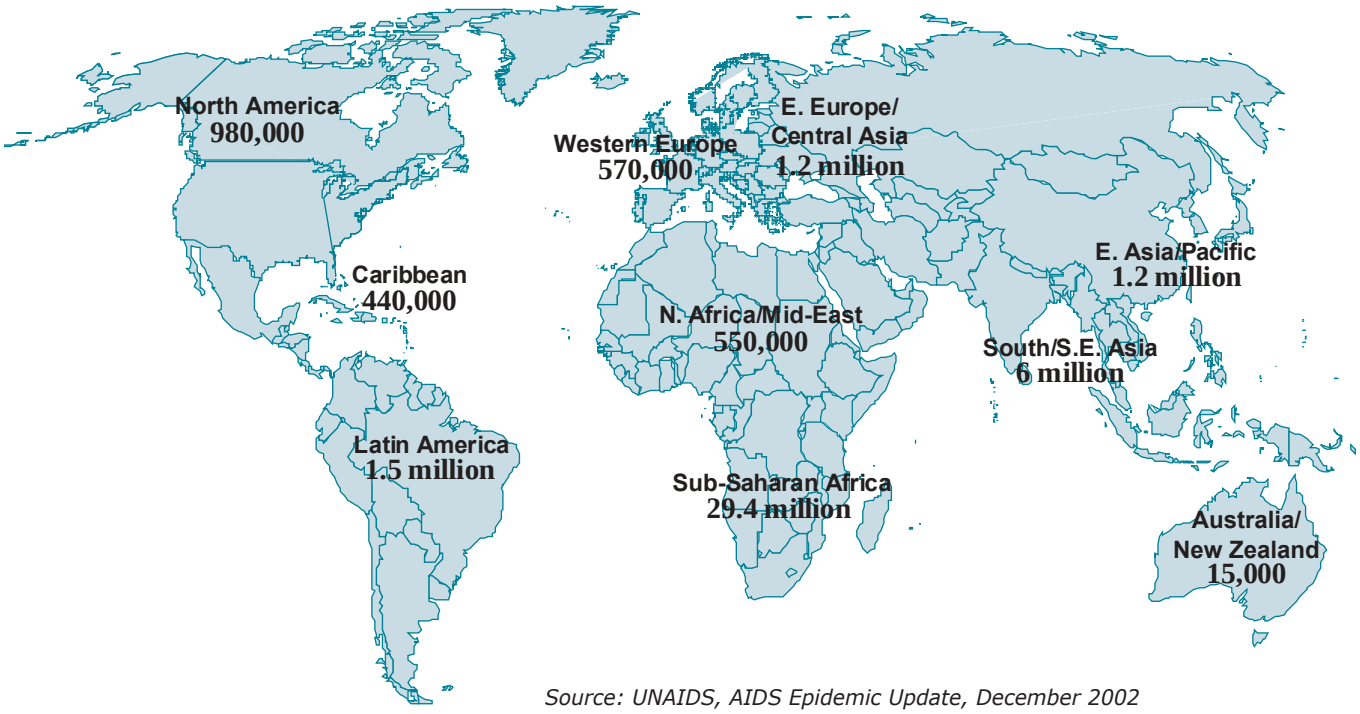
At the end of 2002, 42 million people worldwide were living with HIV/AIDS. Five million people were newly infected in 2002, including 800,000 children under age 15. In the face of these grim statistics, international attention and commitment to fighting HIV/AIDS continue to grow, resources are increasing, and evidence is emerging that prevention strategies are having an impact.

USAID has placed fighting HIV/AIDS among its top priorities. In fiscal year 2001, USAID used increased resources to develop an "expanded response" strategy to the global HIV/AIDS pandemic. The strategy was designed to enhance the ability of countries to prevent new HIV/AIDS infections and provide services to people infected by HIV or otherwise affected by the pandemic, especially children.

In 2002, USAID developed an operations plan to accelerate implementation of the expanded response strategy and maximize its impact. With an increased HIV/AIDS budget of $510 million in 2002, USAID is working in more than 50 countries. The number of "high priority" countries has increased from 17 to 23, with an emphasis on highest prevalence or high risk of emerging epidemic. Four of these countries – Cambodia, Kenya, Uganda, and Zambia – are designated highest priority. In 2001, these "rapid scale-up" countries began receiving significantly increased resources in order to achieve measurable impacts. The operations plan has increased the proportion of funds going

Figure 6

People Living with HIV/AIDS in 2002
42 Million Worldwide



Source: UNAIDS, AIDS Epidemic Update, December 2002

Comprehensive Programs Achieving Country-Level Results

Uganda's experience illustrates how investments in HIV/AIDS prevention can reverse the epidemic's course. In Uganda, USAID has implemented a comprehensive program of interventions, including prevention, care and support, voluntary counseling and testing, and programs for children affected by HIV/AIDS. The investments in these activities, coupled with strong Ugandan leadership and political commitment, an environment of openness and candor, and support from other donors, have led to dramatic declines in HIV prevalence. At the end of 2001, adult prevalence in Uganda was estimated at 5 percent, down from a peak of 15 percent 10 years earlier. USAID is now leading an effort to identify the factors that determined Uganda's success and learn how to apply lessons from Uganda to other countries. USAID also continues to work in Uganda to help the country ensure that successes already achieved are maintained.

Cambodia continues to make progress in reducing adult HIV/AIDS prevalence, which declined from 3.9 percent in 1997 to 2.7 percent in 2001. As USAID's only "rapid scale-up" country outside of Africa, Cambodia received a significant increase in funding in 2001. USAID is implementing a program that includes prevention programs, improved policies, support for children affected by HIV/AIDS, and expanded health services for vulnerable populations.

HIV/AIDS rates in **Zambia** are among the highest in the world. USAID continues to be the largest donor in Zambia for HIV prevention. The Helping Each Other Act Responsibly Together, or HEART, campaign has informed young people about HIV/AIDS, promoted abstinence as a social norm, and encouraged consistent condom use among sexually active youth. The proportion of unmarried young people ages 15 to 24 reporting sexual activity in the past year dropped from 44 to 32 percent among males and from 24 to 16 percent among females. Zambia is being closely watched as a possible second Uganda-type success that can serve as another model for national efforts in Africa.

Bolivia's ability to maintain low HIV prevalence is threatened by high-risk sexual behaviors and high HIV and sexually transmitted infection rates in neighboring countries such as Brazil. USAID has supported the development of a national HIV/AIDS sentinel surveillance system that now extends to key border points with Brazil and Argentina. USAID's intensive behavior change communications and counseling efforts with high-risk groups have contributed significantly to continued low HIV prevalence in the country. In 2001, Bolivia had an estimated adult prevalence of 0.1 percent, the lowest in Latin America.

to the field from 61 to 78 percent. USAID's new Office of HIV/AIDS, established within the Bureau for Global Health as part of an Agency restructuring in 2002, ensures that field programs get the best available support, that assistance is closely coordinated with other U.S. agencies and international donors, and that practical field-based and biomedical research is directed at the most critical challenges.

USAID Strategy and Interventions

USAID's HIV/AIDS strategy employs the following comprehensive and interrelated approaches:

- Preventing HIV transmission
- Providing care and treatment to individuals and communities affected by HIV/AIDS

- Addressing the needs of children affected by HIV/AIDS
- Increasing capacity for surveillance, monitoring, and evaluation
- Increasing the capacity of health systems to address HIV/AIDS
- Working in partnerships
- Providing technical leadership through research
- Creating a supportive environment

USAID continues to expand the scope and scale of its response to HIV/AIDS and is undertaking a number of new initiatives and programs. These are highlighted in the bulleted passages below.

Photo by Marchewka, R.

Preventing HIV transmission. Prevention is the cornerstone of USAID's program. Diagnosis and treatment of sexually transmitted infections, prevention of mother-to-child transmission, voluntary counseling and testing, and mass media and interpersonal communications to decrease risk behaviors are key elements of prevention activities. USAID programs reach high-risk populations with behavior change interventions. Programs for youth promote abstinence, fidelity, and condom use. Special attention is given to expanding successful local approaches to a national scale.

- In 2002, President Bush announced his **International Mother and Child HIV Prevention Initiative**. Through this Initiative, pregnant women will receive HIV counseling and testing. Nevirapine or another drug will be administered to HIV-positive women right before delivery and to their newborns right after birth to prevent transmission of the virus. As appropriate, mothers, infants, and spouses will continue to receive antiretroviral drugs. The Initiative will also support safe infant feeding and build public health infrastructure. Also in 2002, USAID awarded a five-year $100 million grant to the Elizabeth Glaser Pediatric AIDS Foundation to support prevention of mother-to-child HIV transmission in resource-poor countries. Identification of new collaborators in this new area of AIDS prevention and treatment, including faith-based organizations and local partners, is ongoing. These new activities will dramatically expand the types and scale of services available in developing countries for preventing mother-to-child transmission.

Providing care and treatment to individuals and communities. USAID supports care interventions to reduce the impact of HIV/AIDS on individuals, families, communities, and nations. Care and treatment reduce the epidemic's effects and also strengthen prevention efforts. USAID now funds 25 care and treatment projects in 14 countries. USAID supports prevention and treatment of opportunistic infections such as tuberculosis, treatment and care for HIV-related symptoms, and adequate nutrition for people living with HIV/AIDS. USAID is also coordinating with faith- and community-based organizations to develop care and support systems and introduce antiretroviral drug therapies.

- USAID's care and treatment activities have recently expanded to include lifesaving **antiretroviral drug therapies**. Significant

declines in the costs of these drugs have enabled USAID and its partners to integrate antiretroviral treatment and management into prevention and care programs. In three introductory sites in Ghana, Kenya, and Rwanda, USAID is creating antiretroviral treatment models that governments and the private sector can scale up to the national level. The program will build on existing voluntary counseling and testing services and expand the range of medical care and support services available to HIV-positive individuals.

Photo by Nrityanjali Academy

Addressing the needs of children. USAID is currently funding more than 77 activities in 24 countries to support children affected by HIV/AIDS. Many of these activities focus on strengthening the ability of families and communities to provide care and support. Others help children and adolescents obtain an education or support policy development and research. USAID supports community- and faith-based organizations that have been the leaders in helping these children. These organizations provide such services as material assistance, counseling, community-based care, and assistance to parents in planning for their children's future care. Since 2000, USAID has also provided $10 million a year in food aid for children and families affected by HIV/AIDS. Nutritional support can help extend life expectancy and mitigate the impact of AIDS on children, families, and affected communities.

Increasing capacity for surveillance, monitoring, and evaluation. A central feature of USAID's HIV/AIDS strategy is an emphasis on improved information for decisionmakers. This includes systematic collection, analysis, and sharing of data on the epidemic's course, related human behaviors, and program results. This information improves understanding of the epidemic and helps in the planning and targeting of scarce resources for prevention and care. USAID supports monitoring and evaluation programs to measure the impact of interventions, coordinate donor and other partner activities, and implement the most effective, efficient use of resources.

- In 2001, USAID initiated an **improved monitoring and evaluation reporting system** that uses standardized indicators. These indicators were developed in consultation with other national governments, multilateral donors, technical experts, and nongovernmental organizations. They enable program managers to track similar results over time in different countries. USAID also funded the development of the **HIV/AIDS Survey Indicators Database**, which provides data on HIV/AIDS indicators for a number of countries, including data on HIV/AIDS-related knowledge and behaviors.

Increasing the capacity of health systems to address HIV/AIDS. HIV/AIDS strains the resources – including the personnel, physical infrastructure, drug, and supply resources – of developing-country health systems. USAID

helps countries better respond to HIV/AIDS through an array of planning and management tools including national health accounts, pharmaceutical management, and human capacity development. USAID support has been instrumental in developing national HIV/AIDS action plans, including policies for affected children, in several sub-Saharan African countries.

- In fiscal year 2001, USAID developed the **Human Capacity Development Initiative** to strengthen human capacity to lead, plan, implement, monitor, and evaluate expanded HIV/AIDS prevention, care, and support programs. Under this Initiative, USAID is supporting an assessment in 12 African countries to provide USAID and its partners with information about training needs and the resources available to meet them. The Initiative has also made resources available to help USAID Missions formulate human capacity development strategies as part of their proposals for the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

Photo by Coleman, P.

Working in partnerships. USAID works closely with other international donors, national governments, host-country and U.S.-based institutions, community organizations, and the private sector. Such partnerships enable USAID to avoid duplication, ensure broad coverage, monitor the effects of interventions, and identify and share tools, innovations, and successes. Partnerships with community- and faith-based organizations put resources at the front lines of the fight against HIV/AIDS.

- The new **Global Fund to Fight AIDS, Tuberculosis, and Malaria** was established in 2002 to mobilize and increase resources for fighting these diseases on a global scale and to direct resources to prevention, care, and treatment programs in the areas most in need of assistance. The Fund will complement existing programs by attracting, managing, and disbursing additional resources. In May 2001, the United States was the first country to pledge support for the Fund and, as the Fund's largest contributor, has pledged $500 million to date. In addition to fulfilling part of this pledge, USAID has provided additional funds, technical support, and staff to help the Fund's start-up operations.
- In 2001, USAID established two grants programs targeted at community-based organizations responding to HIV/AIDS. The **Communities Responding to the HIV/AIDS Epidemic (CORE) Initiative** aims to strengthen and expand community-level responses to HIV/AIDS. Through the Initiative, USAID provides direct grants, information resources, and organizational development assistance to faith- and community-based organizations. CORE has provided grants to 45 organizations in 29 countries. USAID has also established the **Community REACH** program to facilitate the flow of

grant funds to organizations helping in the fight against HIV/AIDS. These include universities, faith-based organizations, and regional and community-based nongovernmental organizations. The REACH program has awarded grants to seven organizations for voluntary counseling and testing activities and to eight organizations for care and support activities.

Providing technical leadership through research. Investing in research to develop new tools and technologies for HIV prevention is a critical part of USAID's HIV/AIDS strategy. USAID supports the development and evaluation of safe and effective prevention technologies, such as microbicides and vaccines, and the study of emerging issues in HIV prevention, such as the relationship between male circumcision and HIV transmission. In addition, USAID has supported more than 60 operations research studies in 21 countries to test interventions in behavior change, care and support, management of sexually transmitted infections, community mobilization, and stigma and discrimination. Additional information on USAID's research activities can be found in chapter VII of this report.

Creating a supportive environment. HIV/AIDS programs need a supportive context in order to be effective. Prevention and care efforts require political will, leadership, and community involvement. USAID programs fight stigma and discrimination directed against people living with or affected by HIV/AIDS; promote the involvement of people living with HIV/AIDS in prevention, care, and other activities; promote community mobilization; and strengthen the capacity for political and legislative advocacy.

- USAID recently began a **media training partnership** to involve media in the struggle against HIV/AIDS in Kenya and Nigeria. The **Local Voices** program aims to foster a more supportive social environment through an enlightened and committed broadcast community. This activity will provide local broadcasters with the information, resources, and support they need to effectively cover the AIDS pandemic, thus enabling them to contribute to the fight against HIV/AIDS and to society's efforts to cope with its consequences.

Key Achievements

- With an adult HIV prevalence of 5.8 percent, **Nigeria** has the third largest HIV burden in sub-Saharan Africa and the fourth largest in the world. Almost 3.6 million Nigerians are infected with HIV, and 840,000 children and youth have been orphaned by AIDS. USAID and its partners have created a comprehensive prevention and care program that includes changing behavior to avoid or decrease risk; mass media and interpersonal communications; the country's first voluntary counseling and testing centers; a national emergency action plan; and support projects for people living with HIV/AIDS and children affected by HIV/AIDS. As a result of these efforts, prevention messages reached more than 3 million people in fiscal year 2001.
- **Namibia** currently has 47,000 children orphaned by AIDS. With adult HIV prevalence at 22.5 percent in 2001, these numbers are likely to grow significantly. USAID has supported the drafting of a national policy on orphans and vulnerable children and provided assistance in the form of food, books, school uniforms, and counseling to more than 1,000 orphans.
- In 2001, USAID initiated a pilot activity in Odessa *oblast*, **Ukraine**, to reduce mother-to-child HIV transmission and create a sustainable model adaptable to other cities and countries in the region. Project results in 2002 showed that the transmission rate had declined since 1997/99 by 50 percent, from 24 to 12 percent. Early detection of HIV-positive status, an increase in delivery by caesarean section, and administration of antiretroviral therapy to both mother and child contributed to this decline.

- Although HIV prevalence in **Bangladesh** is low, the risk behaviors of some population groups suggest there is a high potential for a serious HIV/AIDS epidemic. USAID's goal is to keep HIV prevalence in high-risk groups below 5 percent through behavior change interventions and by enhancing the capabilities of nongovernmental organizations to provide HIV/AIDS outreach and sexually transmitted infection treatment services. Outreach counseling services held 235,000 peer-to-peer meetings around the country last year, and more than 1 million people in high-risk behavior groups attended group sessions on HIV education and prevention. Another 42,000 people received treatment for sexually transmitted infections.
- In **Rwanda**, access to quality clinic-based HIV/AIDS services is very limited for anyone living outside the capital of Kigali. USAID has provided technical assistance, materials development support, training, and equipment to help establish services across the country. USAID is currently assisting 18 voluntary counseling and testing centers in six of the country's 11 provinces. Four of these centers opened in the last year. Two sites for preventing mother-to-child HIV transmission (the third and fourth funded by USAID) and two pilot sites outside Kigali for prevention and treatment of opportunistic infections also opened. One USAID-supported activity provided prenatal HIV/AIDS counseling to more than 2,000 pregnant women; voluntary HIV/AIDS testing to more than 85 percent of these women; and nevirapine treatment to 49 HIV-positive women and 57 infants.

Photo by Nelson, H.

V. Vulnerable Children

Photo by USAID/Destler, H.

V. Vulnerable Children

Activities for vulnerable children address the special needs of children in crisis or high-risk situations by strengthening the ability of families and communities to respond to these needs. USAID provides assistance for vulnerable children through three activities: the Displaced Children and Orphans Fund (DCOF), programs for blind children, and programs for other vulnerable children. USAID programs for children affected by HIV/AIDS are described in chapter IV of this report.

The Displaced Children and Orphans Fund, established in 1989, primarily addresses the needs of vulnerable children affected by war, poverty, and disabilities. DCOF stresses the importance of families, communities, and local organizations as front-line resources for providing care and protection to the most vulnerable children. Having provided more than $125 million of assistance in 40 countries over the past 13 years, DCOF programs work to develop and strengthen the capacity and sustainability of local government agencies, nongovernmental organizations, and small grassroots organizations. The focus is on programs that benefit children directly, such as life-skills training, nonformal education, and income-generating activities that assist at-risk families.

In supporting programs for blind children, USAID is a partner in the global initiative to eliminate avoidable blindness by the year 2020. Childhood blindness has far-reaching implications for children and their families. It affects access to education, prospects for employment, and quality of life. In most developing countries, eye health is not a high priority. Many children with preventable eye diseases are not identified or referred to eye health services. USAID is addressing these concerns with cost-effective, equitable, and sustainable community-based programs supported through grants to the International Eye Foundation, Helen Keller International, and country-based child health and development programs.

Activities for other vulnerable children identify and support innovative approaches to problems that put children at risk, such as family breakup. Examples of such activities include support for youth centers for street children and vocational training.

Photo by JHU/Reilly, E.

USAID Strategy and Interventions

DCOF programs aim to improve the safety and security of children affected by war, poverty, or disabilities, and to promote the development, psychosocial well-being, and social integration of these children within their families and communities.

Program priorities include:

- Keeping children in school and helping those out of school return
- Providing opportunities for war-affected children to play, express themselves, and experience a more normal life
- Preventing the recruitment of children into military forces or other armed groups by providing alternatives such as education, training, and economic opportunities
- Preventing the sexual exploitation and abuse of children
- Supporting family reunification and community reintegration for separated children

Photo by PAHO/Waak, A.

Family Strengthening. DCOF activities accomplish their objectives by improving the abilities of families to protect and care for their children. DCOF supports economic strengthening to enable families to better provide for their children's educational, nutritional, and health needs. DCOF also promotes community support for vulnerable households and increased recognition and understanding of children's needs and rights.

Community Mobilization. DCOF programs mobilize and strengthen the capacity of communities to protect and promote the well-being and development of vulnerable children. Community mobilization is a process through which communities define their priority concerns for children, decide what they can do to better address these concerns, and take action. Communities are defined as people living in physical proximity, regardless of ethnicity.

Child Development. DCOF-supported organizations strengthen the ability of children to better meet their own physical, psychosocial, and developmental needs through education, family reunification, and psychosocial support.

Creating a Supportive Environment. DCOF promotes information sharing, partnerships, and collaboration among organizations, government agencies, religious networks, and the private sector to improve the safety and well-being of children and promote their development.

DCOF programs do not support institutional care, significant infrastructure development, major relief donations, or, except in rare cases, direct payment of school fees.

USAID support for programs for blind children focuses on blindness prevention and correction of sight deficiencies. These programs promote community awareness of preventable childhood eye diseases through materials development, training, and community- and school-based education campaigns. Eye health services for children are strengthened and integrated into existing health care services. Centers that provide cataract surgery and follow-up are increasing coverage for children with cataracts. Low-vision and rehabilitation centers are helping visually disabled children achieve scholastic and economic independence. School-based screening is identifying children with myopia, hyperopia, or astigmatism, who are then provided with low-cost eyeglasses. Programs receiving USAID support are located in Bangladesh, Egypt, El Salvador, Guatemala, India, Malawi, Mexico, Morocco, Nigeria, the Philippines, South Africa, and Tanzania.

Key Achievements

Last year, approximately 370,000 children benefited from DCOF-supported activities. These and other important activities for vulnerable children included the following:

- In **Brazil**, DCOF has been supporting activities since 1994 to assist at-risk urban children and youth in the national capital Brasilia and in three state capitals in Brazil's northeast region. The program has achieved outstanding results in combating sexual exploitation of children and adolescents; preventing HIV/AIDS and early pregnancy; preventing child labor; and providing vocational training, particularly in market-driven and innovative areas of employment. More than 3,500 children have been direct beneficiaries, and another 40,000 family members and peers have received assistance. Awareness campaigns are reaching as many as 18,000 students and teachers in more than 600 schools. The project has become a national reference for local nongovernmental organizations assisting at-risk children and youth in Brazil.
- In **Burkina Faso**, an estimated 1,850 orphans and other vulnerable children have benefited from direct community support through a USAID-funded project. With the help of the project, 668 children have enrolled in school. Some 600 children receive regular monitoring home visits from about 100 volunteers, and more than 200 children have received emergency support through medical, clothing, or food assistance.
- In **Sierra Leone**, a USAID-funded project has helped local governments become more effective in protecting children by facilitating standards of good practice and coordination among local, national, and international nongovernmental organizations. The project traces, identifies, and cares for separated children and demobilized child soldiers. It also reunifies families and reintegrates children into their communities. In 2000, 91 percent of the caseload of separated children (including former child soldiers) were reunited with a family member. In 2001, 52 percent were reunified. Most children who were not reunited with their families have been placed in foster families or community-based care appropriate to their ages and needs.

Photo by Lutheran World Relief

- In the **Democratic Republic of the Congo**, DCOF works with a range of local organizations to improve the protection of war-separated children, child soldiers, and street children by reuniting and reintegrating them with their families and communities. DCOF provides technical support to partners involved in tracing and reintegration activities through training, guidance, and supervision. During the past year, 230 Rwandan children separated by war have been repatriated. More than 400 Congolese children have been reintegrated into their families, including 223 demobilized child soldiers.
- In **Vietnam**, USAID is supporting four programs to include children with disabilities in mainstream classrooms. In 2001, the project's success in serving 2,400 children in three northern provinces led the Ministry of Education and Training to invite USAID and its grantees to help make inclusive education a part of the National Education Strategy. USAID is also supporting state-of-the-art orthotics workshops at two of Vietnam's leading hospitals. The program has made high-quality braces and provided medical rehabilitation for more than 2,500 children suffering from cerebral palsy, clubfoot, and other ail-

Photo by Lutheran World Relief/Frerichs, J.

ments. In 2001, the program expanded to assist self-help groups of parents of disabled children and became a major contributor to a rapidly developing national movement to organize and empower people with disabilities. With USAID support, Vietnam has established a National Coordinating Committee for Disabilities. A national association of disabled people to support advocacy, vocational training, and employment is in the planning stages.

- In **Liberia**, USAID supports a program of physical rehabilitation services to facilitate the socioeconomic reintegration of the physically disabled. Through the program, 422 adults and 467 children received physical rehabilitation services. Lower-limb prostheses were provided to 244 adult and 210 child amputees, and 132 children underwent corrective surgery for disabilities due to polio and other causes.
- In **Russia**, USAID's efforts in support of vulnerable children have evolved from helping nongovernmental organizations develop community-based services to fostering regional systems for addressing problems. Since 1999, more than 10,000 children and 7,000 families have benefited from USAID assistance. More than 80 grants have supported services for such disabilities as autism, cleft palate, cerebral palsy, and hearing and vision impairments. USAID-supported efforts are helping families with disabled children cope better and keep their children in the family environment. Foster care is being developed as an alternative to institutions, and older children in institutions are receiving special care and training to improve their ability to live in the outside world. In Novgorod *oblast*, USAID has supported the development of a regional system of early intervention centers for children under 3 years old who have special needs. The centers have served nearly 1,600 families.

VI. Infectious Disease Initiative

Photo by JHU/CCP/Mwanza, L.

VI. Infectious Disease Initiative

The goal of USAID's Infectious Disease Initiative is to reduce the threats of infectious diseases of major public health importance. The Initiative focuses especially on tuberculosis and malaria and also works to contain resistance to drugs used to fight infectious diseases and improve disease surveillance and response. USAID's efforts to control infectious diseases such as acute respiratory infections, diarrheal diseases, vaccine-preventable diseases, and HIV/AIDS are addressed through other USAID programs.

Within the Infectious Disease Initiative, USAID works with partners from international organizations, U.S. agencies, nongovernmental organizations, universities, and the private sector to strengthen and expand global, regional, and national initiatives and programs. The Agency has continued to play an important role in developing and expanding global initiatives such as the Global Partnership to Stop TB, the Global TB Drug Facility, and Roll Back Malaria. USAID also played a key role in establishing the Secretariat of the Global Fund to Fight AIDS, Tuberculosis, and Malaria and in creating the Fund's monitoring and evaluation strategy. At the regional and national level, USAID activities have established, strengthened, and expanded country programs throughout the world.

Tuberculosis

Tuberculosis remains one of the world's deadliest infectious diseases, killing more young people and adults than any other infectious disease. Of the estimated 2 billion people infected with tuberculosis, 8 million develop active TB each

Onchocerciasis Control Program Ends Its Work in West Africa

For centuries, onchocerciasis – also known as river blindness – has taken the sight of people in West Africa. A debilitating parasitic disease passed through the bite of a black fly, onchocerciasis devastated the lives and livelihoods of farming families in riverside agricultural areas. In 1974, USAID, other donors, and national governments established the Onchocerciasis Control Program in 11 West African countries. The program sprayed larvicides, provided essential drugs through a public-private partnership with the U.S. pharmaceutical company Merck, and strengthened disease surveillance and public health management. Since the Program's inception, USAID has been its largest donor, contributing $75 million to the World Bank-administered Onchocerciasis Trust Fund. In December 2002, the Program declared victory and formally ended its work, having dramatically reduced prevalence rates and transmission potential to levels that no longer pose a major public health problem in the program area. As a consequence, more than 40 million people have been protected from onchocerciasis and more than 600,000 cases of blindness have been prevented. In addition to its health impact, the Program helped re-establish agriculture on more than 25 million hectares of arable land once abandoned due to the disease. This has allowed enough new agricultural production to feed an additional 17 million people annually. USAID and other donors continue to support onchocerciasis control efforts in 19 other African countries where the disease remains prevalent.

year and 2 million die. Developing countries have 95 percent of the world's TB cases and 98 percent of TB deaths. The persistence of tuberculosis on a global scale is due chiefly to poverty, lack of resources and staff, emerging drug resistance, increasing HIV/AIDS prevalence, and decreasing investments in public health systems.

In 1998, WHO launched the Global Partnership to Stop TB. The cornerstone of this partnership is the "directly observed treatment, short course," or DOTS, strategy, a comprehensive approach that has significantly increased cure rates and reduced the emergence of multidrug-resistant TB through an emphasis on case identification and prompt effective treatment. To date, about 150 countries have adopted the DOTS strategy as the guiding principle for national tuberculosis control. Many countries fall short, however, of implementing the approach nationwide.

USAID Strategy and Interventions

USAID is committed to the Stop TB partnership and the DOTS strategy, focusing on six key areas:

- Supporting DOTS expansion and improving DOTS performance in key countries
- Increasing and strengthening human resource capacity in the developing and developed worlds
- Improving the synergy between TB and HIV/AIDS interventions
- Addressing TB drug resistance through surveillance and improved treatment

Figure 7

Countries Receiving USAID Assistance for TB Control

- Developing and disseminating new approaches and tools for controlling TB
- Monitoring and evaluating TB programs and assessing their impact on the TB epidemic

In fiscal year 2002, USAID's TB budget increased dramatically to over $75 million, which allowed for the expansion and strengthening of the DOTS strategy in more than 35 country and regional programs, the expansion of global initiatives, and support for research into new approaches to control TB.

Key Achievements

Global TB Drug Facility. As a member of the Stop TB partnership, USAID has supported the creation of the Global TB Drug Facility (GDF) in order to rapidly and efficiently provide inexpensive TB drugs to countries in need. In 2002, USAID provided $2 million for drugs along with technical assistance for identifying recipient countries. USAID also seconded a full-time drug logistics and management specialist to the GDF to provide drug management guidance to recipient countries. To date, the GDF has provided drugs to 14 countries. The establishment of the GDF has resulted in a 30 percent drop in the price of TB drugs, thus making them more accessible for all countries.

Technical Assistance for TB Drug Management. The Agency supported activities to ensure that countries are prepared to manage large quantities of TB drugs. The first TB Drug Management Workshop examined the management capacity of countries receiving or applying for large donations from the GDF. Since then the GDF has used the "Drug Management for Tuberculosis" tool, developed with USAID support, to evaluate national drug management practices. Experts have helped teams in India, Indonesia, Kenya, Moldova, Tajikistan, and Togo make recommendations for streamlining drug distribution and monitoring proper drug utilization by national programs.

International TB Training. Through its partnership with the TB Coalition for Technical Assistance, USAID took the lead in developing an international TB Task Force on Training. The goals of the Task Force, which includes the Stop TB partners, include developing a global strategy for building TB prevention and control capacity, setting quality standards, and developing training plans. USAID has funded ongoing regional programs in Latin America, Africa, Asia, Eurasia, and Europe to update and build the skills of national TB program staff. In the past year, 382 health care professionals from USAID target countries participated in these programs.

Photo by Shapera, T.

Community TB Services in Malawi and Uganda. USAID has been supporting community TB treatment services in Malawi and Uganda. Malawi has already attained countrywide coverage, while Uganda is implementing services in 24 of 56 districts with plans for national coverage within two years. USAID is supporting the expansion of this approach in other African countries.

The "ProTEST" Initiative. In response to the growing problem of TB/HIV co-infection, USAID is looking for ways to provide more accessible services for people with co-infections. USAID is supporting WHO's "ProTEST" Initiative, which aims to deliver coordinated interventions for TB and HIV prevention and care. "ProTEST" uses voluntary counseling and testing as an entry point for access to a variety of HIV and TB interventions. Pilot project sites in Malawi, South Africa, and Zambia have served more than 70,000 individuals over the past four years.

Postwar Support for TB Programming in DR Congo. USAID has been involved in re-establishing the national tuberculosis program in Maniema and Kasai provinces of the Democratic Republic of the Congo. Funds have been provided to equip and strengthen laboratories, support technician training, and improve monitoring and supervision. USAID has initiated the process of extending DOTS into 63 health zones and has also supported training, the renovation of the National Reference Laboratory, and publication of the national tuberculosis policy.

DOTS Strategy in Honduras and El Salvador. USAID has supported the implementation and expansion of the DOTS strategy in all health regions in Honduras. During 2001, 95 percent of the health facilities were fully implementing DOTS. The cure rate for the latest cohort was 85.4 percent. In El Salvador, USAID assistance helped the Ministry of Health achieve an 80 percent cure rate in 2001. All Ministry facilities implemented DOTS, and the laboratory network was greatly improved. DOTS training programs are also targeting private physicians, the Social Security Institute, and medical and nursing schools.

Meeting TB Challenges in Kosovo. USAID, partners from the European Union, and the private voluntary organization Doctors of the World have supported the tuberculosis program in Kosovo for the past two years. Despite the challenges presented by the lack of government and the separate health care systems for Albanians and Serbs, the region has more than 95 percent DOTS implementation and an 84 percent treatment success rate in new smear-positive patients.

DOTS and Improved TB Control in India. Since 1998, USAID has contributed over $11 million to help implement, expand, and improve the DOTS strategy in India. Activities have provided training, technical support, and monitoring and evaluation in Tamil Nadu and Uttaranchal states, with future plans to carry out similar activities in Haryana. USAID has also supported operations research to monitor multidrug-resistant TB and to determine if DOTS can be improved by using community volunteers. USAID support complements other larger investments to improve TB control in India. A recent review reported steady progress over the past eight years in strengthening the national TB program. More than 200,000 health workers have been trained, and more than 40 percent of the population has access to TB services.

Malaria

From 300 million to 500 million cases of malaria occur worldwide every year, causing up to 2.5 million deaths. Most of the victims are young children. Malaria affects the health and wealth of nations and individuals alike. In Africa, it is both a disease of poverty and a disease that causes poverty. It is a major constraint to economic development. As a result, the international community has remobilized in the past few years to develop and implement sustainable actions against malaria.

USAID Strategy and Interventions

During the past year, USAID continued to support the Roll Back Malaria (RBM) initiative.

The Agency assisted 22 national malaria programs and three regional initiatives, continuing to build malaria control networks and develop new technologies and approaches. USAID provided significant support to "going-to-scale" efforts in national malaria control programs in Africa and to cross-border initiatives addressing the problem of resistance to antimalaria drugs.

USAID is reducing malaria morbidity and mortality by focusing on six key areas:

- Preventing malaria infection and illness
- Promoting effective treatment of malaria illness
- Protecting pregnant women from malaria
- Responding to the emergence and spread of drug-resistant malaria
- Developing new tools and approaches for malaria prevention and control
- Addressing malaria in populations in complex humanitarian emergencies

Addressing malaria in humanitarian emergencies was recently added to the strategy after it was determined that up to 30 percent of Africa's malaria deaths occur in countries in the midst of war, civil strife, food shortages, or large population displacements.

Key Achievements

Strengthening Roll Back Malaria. USAID has been a key partner in the RBM initiative since its inception in late 1998. This year the RBM partners carried out an extensive external review of its progress. USAID contributed team members and special studies to examine the status of RBM work in monitoring and evaluation, communications and behavior change, and complex emergencies. The report of this in-depth evaluation spurred a significant revision and revitalization of the partnership's governance structures and emphasis. USAID is also supporting WHO's Regional Office for Africa in expanding its monitoring and evaluation of RBM activities.

Malaria Vaccine Development. In collaboration with public and private partners, USAID focuses on developing and testing malaria vaccines through its Malaria Vaccine Development Program. In the latest step forward, field-testing of a single-component malaria vaccine has begun in Kenya.

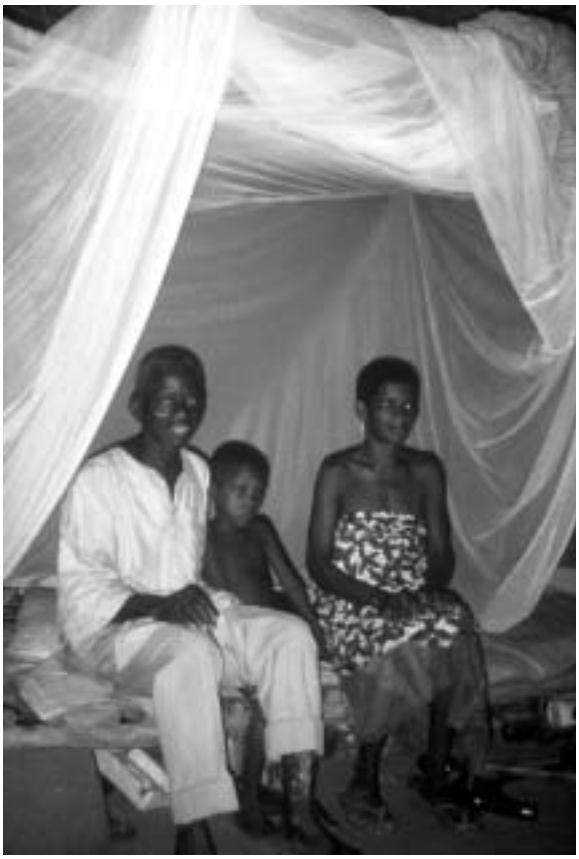
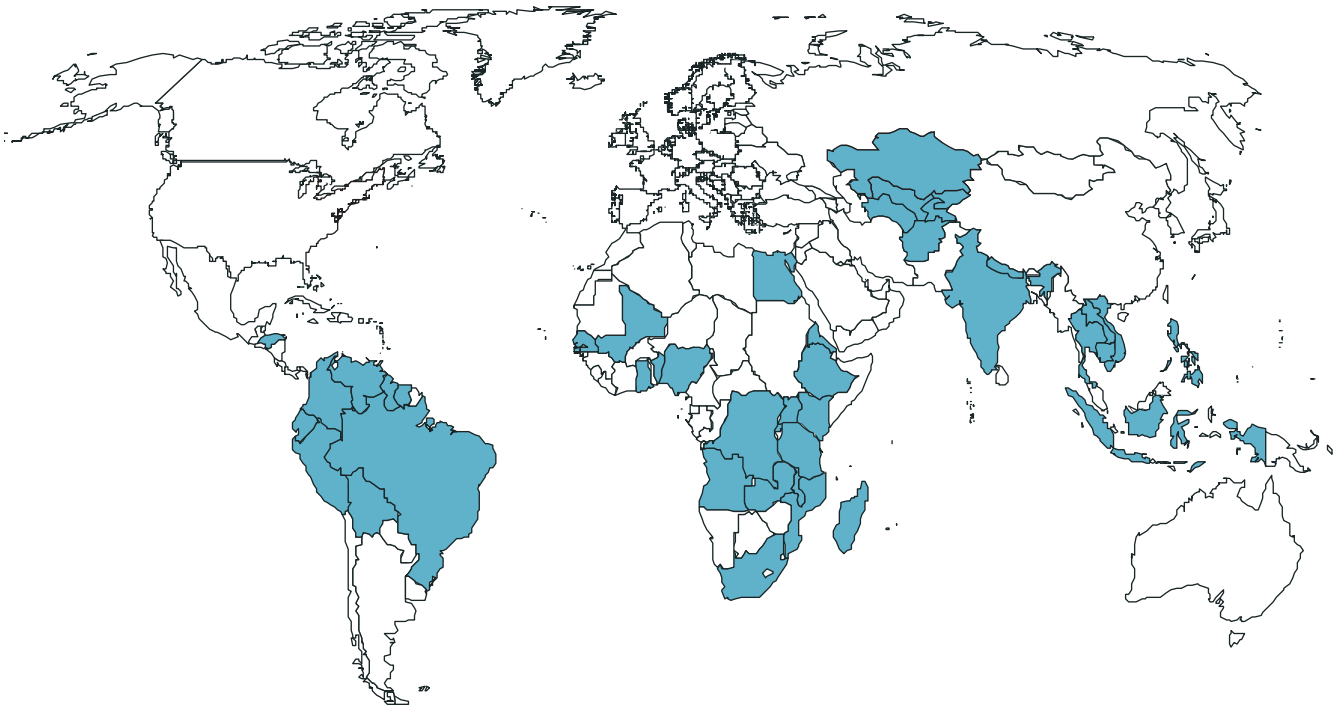


Photo by Lutheran World Relief/Kull, B.

NetMark Partnership. Research has shown that sleeping under an insecticide-treated bednet (ITN) can reduce mortality by up to 63 percent and morbidity by at least 40 percent, particularly among children under age 5 and pregnant women. To help stimulate commercial investment in ITNs, USAID has launched NetMark, an innovative program that has formed partnerships with 13 major firms (representing over 80 percent of the global capacity to produce and distribute ITNs) to develop ITN markets and

Figure 8

Countries Receiving USAID Assistance for Malaria Control



expand the availability of affordable ITNs in five African nations. The program has helped eliminate taxes and tariffs on ITNs in Mali, Senegal, and Zambia. In 2002, it launched ITN marketing in Ghana, Nigeria, Senegal, and Zambia, selling more than 600,000 ITNs and 500,000 insecticide re-treatments during its first five months of operation.

Effective National Policies in DR Congo. Malaria infection in the Democratic Republic of the Congo is becoming more severe as a result of an outdated treatment policy, poor diagnostic capacity, and environmental degradation. USAID support focuses on improving the capacity of the National Malaria Control Program to develop and disseminate effective treatment and clinical management policies. A national malaria policy has been developed, and new treatment guidelines have been distributed. In response to reports of high chloroquine resistance, a new drug policy has replaced chloroquine with sulfadoxine/pyrimethamine.

Antimalarial Drug Resistance. In Africa as elsewhere, growing antimalarial drug resistance is challenging malaria control. New drugs exist but are significantly more costly than current therapies. With USAID support, an Institute of Medicine panel is developing guidance for the RBM partnership on the most efficient means of financing these newer, more effective treatments. USAID is supporting operations research to study issues affecting the introduction of combination drug therapies in Africa and has also supported the preparation of a document on related regulatory requirements.

New Tools for Malaria Management. USAID supported the development of a community malaria management tool in Africa and the Mekong Basin countries of Southeast Asia.

The tool will help identify and explore factors associated with access to drugs, consumer care-seeking behaviors, and other practices that affect the spread of multidrug-resistant malaria in these areas. The tool, which is being applied in Cambodia, Thailand, and Senegal, will develop indicators for surveillance of drug use behaviors and identify interventions to promote a more rational approach to treatment. USAID has also addressed poor antimalarial drug quality in Africa and Southeast Asia by supporting assessments and analyses of drugs available through the public sector and in both formal and informal private facilities. The findings demonstrated that both substandard and counterfeit antimalarial drugs are widespread. Interventions and training to help countries monitor and respond to this problem will take place in the coming year.

Malaria Action Coalition. In 2002, USAID developed the Malaria Action Coalition to coordinate technical assistance in Africa for achieving the RBM targets of 60 percent treatment of malaria illness, particularly in children under age 5, and 60 percent access of pregnant women to presumptive malaria treatment. The Coalition will work with regional groups, national governments, and private partners to engage in policy dialogue, strategy development, operations research, monitoring and evaluation, and performance improvement activities. Areas of activity will include epidemiology; behavior change; improved drug management, regulation, and practices; and pilot interventions in such areas as antenatal and maternal health care.

Antimicrobial Resistance

Continued success in reducing the global burden of infectious diseases is increasingly threatened by the emergence and spread of disease-causing microbes that are resistant to treatment drugs. Antimicrobial resistance renders first-line therapies for tuberculosis, malaria, acute respiratory infections, sexually transmitted diseases, and HIV/AIDS ineffective. This is a serious problem

Photo by JHU/CCP

for many countries that do not have access to more expensive second-line therapies, which have increased side effects and more complex treatment regimens. Meanwhile, new drugs are not being produced fast enough to keep up with increasing drug resistance.

USAID Strategy and Interventions

USAID's objective in responding to antimicrobial resistance is to preserve the effectiveness of currently available and affordable antimicrobial drugs. USAID's three-pronged effort seeks to:

- Decrease the use of antimicrobial drugs when they are not needed
- Improve the use of antimicrobial drugs when they are needed
- Ensure the quality and regular supply of essential antimicrobial drugs

Multifaceted solutions are necessary because many pharmacologic, biologic, behavioral, cultural, economic, and regulatory factors affect the development and spread of antimicrobial resistance. USAID is focusing on how best to help countries initiate or expand local and national activities to contain drug resistance.

Key Achievements

Advocacy on Global Initiatives. USAID continued its advocacy in support of strategies for

minimizing the development and spread of drug resistance. This is especially critical as new initiatives such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria begin to supply large amounts of pharmaceuticals to countries that may not have systems to manage and use them appropriately. USAID's advocacy and technical assistance has helped ensure that Global Fund proposals reflect the importance of containing antimicrobial resistance and

Photo by Fisch, A.

assessing the capacity of health systems to manage pharmaceuticals.

Improving Use of Medicines. Through support to the Joint Research Initiative for Improving the Use of Medicines, USAID has been building research capacity around the globe to discover effective interventions for improving drug use by consumers and drug prescribing and dispensing by health providers. Research has demonstrated that targeted, behaviorally focused interventions can achieve large impacts on prescribing practices. A study involving Vietnamese district hospital physicians brought about an increase in appropriate prescribing for acute respiratory infections (ARI) from 35 to 57 percent and a one-third reduction in unnecessary prescribing for non-ARI conditions.

Latin America and Caribbean Antimicrobial Resistance Initiative. This initiative is introducing approaches to improving antimicrobial drug use in nine countries in Latin America and the Caribbean. It is also providing training and reference materials to improve laboratory capacity for monitoring antimicrobial resistance. As of 2002, seven countries had established national networks to monitor antimicrobial resistance, with six of them already achieving the laboratory quality control target of 95 percent. Regional treatment guidelines to promote rational use of antibiotics were launched in 2002, and national adaptation activities are ongoing.

Surveillance

High-quality infectious disease surveillance is critical to policy setting, planning, service delivery management, and disease outbreak response. Developing the capacity to use surveillance information requires focusing on both "supply" and "demand." Supply-side activities include developing standardized definitions, forms, and procedures; training health staff in diagnostic techniques; and building laboratory capacity. Demand-side activities involve the use of surveillance information by health care workers and the development of a "culture of information" in which all health care workers value and use high-quality surveillance information.

USAID Strategy and Interventions

USAID has developed a strategy that addresses key aspects of the supply of and demand for

surveillance information. On the supply side, the focus is on

- Improving diagnostic capability
- Developing appropriate analytical tools for local use
- Developing country-based field epidemiology skills

On the demand side, the strategy focuses on

- Behavioral change strategies to strengthen the use of surveillance information
- Improved ability of health care workers and policymakers to act on surveillance information and respond effectively

Key Achievements

Integrated Disease Surveillance and Response Strategy in Africa. In 1998, WHO's Regional Office for Africa developed a regional strategy for integrated disease surveillance and response based on data collection. USAID has provided support for staff, guidelines development, epidemic response, training workshops, and key laboratory reagents. Assessments of national disease surveillance systems have taken place in 28 countries (out of 46 countries in total). National five-year plans for developing integrated disease surveillance and response have been completed in 23 countries. In 2002, four countries adopted the guidelines, and 10 began the adaptation process. Laboratory activities are being strengthened through an external quality assurance program in bacteriology in which 36 laboratories have enrolled.

Strengthening Epidemic Preparedness in Africa. USAID has supported efforts to strengthen Africa's regional capacity for epidemic preparedness and response. USAID has provided preparedness and response assistance to Côte d'Ivoire, Ghana, and Guinea for yellow fever outbreaks; to Angola, Benin, Burkina Faso, Democratic Republic of the Congo, Ethiopia, Mali, Niger, and Uganda for meningitis outbreaks; and to Congo-Brazzaville and Gabon for Ebola viral haemorrhagic fever outbreaks.

Field Epidemiology Training. USAID is using reconstruction funds from Hurricanes Mitch and Georges for a project to strengthen public health surveillance and epidemiological skills in Central America, Haiti, and the Dominican Republic. The project will help these areas develop and integrate field epidemiology training programs in their health ministries. A regional secretariat and technical committee are now in place, and the committee is developing protocols for candidate selection, trainee supervision and assessment, and support for trainee investigations. The National Autonomous University of Nicaragua has developed a curriculum, and the first students have graduated from the CDC Data for Decisionmaking Course. Local universities in Costa Rica, El Salvador, Guatemala, and Nicaragua have adopted this activity.

Infectious Disease Training in the Philippines. A stumbling block to infectious disease control in the Philippines has been the limited abilities of government health workers to identify and manage TB, malaria, and dengue fever. USAID has funded technical assistance and training for government health workers. More than 1,000 health staff from 48 municipalities and three cities have received training on disease surveillance, diagnosis, and management.

Looking Forward

In TB control and prevention, USAID will continue to support international, regional, and national efforts to implement and expand the DOTS strategy. USAID will invest in finding new approaches to implementing DOTS, such as community-based approaches, improved health care services addressing TB/HIV co-infection, and expanded roles for public-private partnerships and private voluntary organizations.

USAID will also continue to respond to the growing demand for improved TB drug management through the Global TB Drug Facility and national TB programs.

With the refocusing of Roll Back Malaria, USAID will continue its key support for achieving RBM goals in Africa. USAID will support increased availability of insecticide-treated bednets through NetMark and strengthened capacity of local partners through the Malaria Action Coalition. The Agency will continue to support public-private partnerships and partnerships with schools of public health in Africa. Improved drug policies will be important to ensure the availability of effective drugs, reduce the spread of drug-resistant malaria, reduce the consequences of malaria in pregnancy, and identify new combination drug therapies.

Through an initiative with the Voice of America, USAID will continue to raise awareness of antimicrobial drug resistance at global, national, and local levels. Voice of America will develop targeted messages on antimicrobial resistance and build the capacity of health journalists in developing countries to report on the subject. The coverage will use local evidence of inappropriate drug use and drug quality problems and will promote changes in drug use behaviors through phone-in talk shows, special reports, storytelling, radio dramas, and interviews with experts.

In disease surveillance, program efforts will focus on identifying obstacles to data collection and use and on strengthening the link between receiving surveillance information and responding to it. New community-based approaches to diagnostics, including rapid diagnostic tests, will be considered for their potential to overcome insufficient laboratory capacity and other resource shortages. USAID will also continue to strengthen and expand field epidemiology training programs around the world.

Photo by Fisch, A.

VII. Research, Technical Innovation, and Health Systems Strengthening

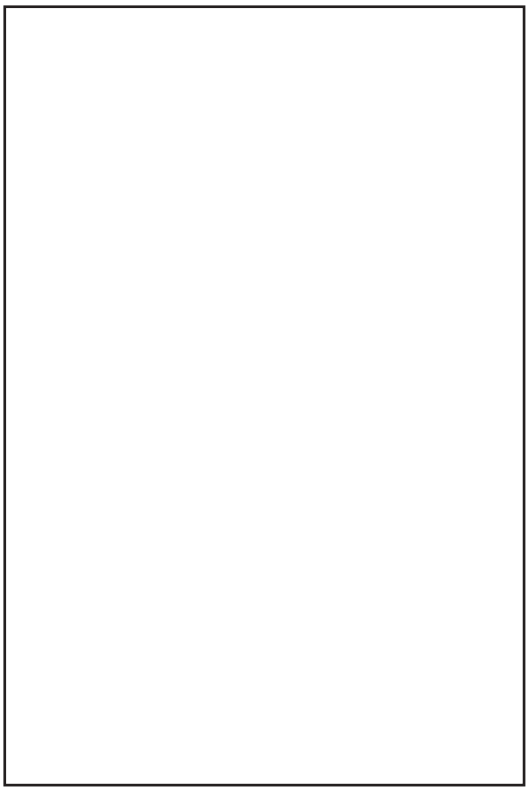


Photo by Urdaneta, C.

VII. Research, Technical Innovation, and Health Systems Strengthening

Photo by Goldsmith, L.

Research and technical innovation build the scientific and empirical base for effective, efficient, high-quality health programs. By developing, testing, and disseminating new technologies, these activities provide the foundation for new approaches to combating critical health problems and strengthening program effectiveness. Improvements in health systems can help developing-country governments make better decisions about planning and resource allocation. This often involves strengthening the ability of developing countries to collect, analyze, and use health information.

USAID Strategy and Interventions

USAID's Bureau for Global Health is a leading sponsor of biomedical, operations, and social science research to generate new technologies and program approaches. After testing in a variety of field settings, these innovations may be adapted, applied, and institutionalized in national programs. USAID is also a leader in collecting data to support program and policy design and in developing indicators and methods to monitor and evaluate program success and health sector trends.

Developed countries have experience with a wide range of tools and strategies that can improve health policies and systems in the developing world. USAID provides technical assistance to adapt these tools and strategies for use in developing countries, especially in the areas of health care financing, quality assurance, and drug management.

Key Achievements

Over the years, USAID-supported research has played a key role in developing and promoting the use of new health technologies and system innovations. Oral rehydration salts, new contraceptive and birthing methods, simple disease diagnosis systems, and the use of vitamin A to enhance child survival are among the most notable of these successes. Achievements and developments of the past year in research, technical innovations, and systems development follow.

Biomedical Research

Biomedical research to develop and test technologies for disease prevention is a hallmark of USAID programs. USAID is also the largest bilateral donor in the field of contraceptive research and development. Biomedical research activities supported by USAID include the development of new methods of contraception, disease prevention, and disease treatment; improvements in existing technologies; and the introduction and support of these innovations in service delivery programs.

Microbicide Development. USAID has supported microbicide research for more than 10 years as part of its HIV/AIDS prevention strategy and reproductive health program. In 2001, six potential microbicides were tested for safety in phase I clinical trials. All of them performed very well and have potential for future clinical development. In fiscal year 2003, cellulose sulfate will

be tested in effectiveness and safety studies. Another product, polystyrene sulfonate, is in preparation for testing by pharmaceutical manufacturers. Most products under study work as both microbicides and contraceptives, although one non-contraceptive microbicide is also being developed. Such a product could benefit couples who want protection from HIV infection that will not interfere with their ability to conceive.

HIV Vaccines. USAID is working with governmental and nongovernmental partners on the development of a vaccine against HIV. USAID is also providing funding to the International AIDS Vaccine Initiative to identify promising HIV vaccine candidates and advance them to field trials once their safety and effectiveness have been established. With USAID's assistance, the Initiative is establishing seven "vaccine development partnerships" to link scientists in developed and developing countries with their counterparts in private industry. This team approach is using the latest in recombinant DNA technologies and provides the necessary technical, organizational, and financial resources to support vaccine development.

Improving the Effectiveness of Vasectomy. The most common vasectomy procedure in developing countries involves a simple tying and cutting procedure. After several years, failure rates for this procedure may be as high as 4 percent. USAID-supported research in seven countries has found that an additional sewing procedure called fascial interposition is likely to improve effectiveness. This finding will help providers improve their technical approach and client counseling.

Micronutrients and Infectious Diseases. In Papua New Guinea, vitamin A and zinc trials have sparked new interest in the potential of these micronutrients to have a significant impact on re-emerging infectious diseases such as malaria and tuberculosis. A dramatic 35 percent reduction in clinical malaria attack rates, as well as reductions in other indicators of malaria severity, occurred in communities where children received routine vitamin A supplements. In the same communities, malaria attack rates in preschool children were reduced by 40 percent with daily zinc supplementation.

The Copper IUD and Fertility. Family planning providers have generally been cautious about providing intrauterine devices (IUDs) to women who have never given birth. Risks of IUD use include IUD expulsion and pelvic inflammatory disease, both of which increase a woman's risk of infertility. A USAID-supported study involving more than 1,300 infertile women in Mexico has shown that previous use of the copper IUD (the only kind supplied by USAID) is not associated with infertility. This research suggests that the copper IUD – one of the safest, most effective, and least expensive long-term methods of reversible contraception – is an appropriate contraceptive method for women who have never given birth and are not at risk for a sexually transmitted infection.

Operations Research

USAID supports operations research to answer questions about the best ways to implement interventions. Typical research areas include the feasibility, sustainability, acceptability, and impact of interventions.

Community-Based Health Care. A USAID-assisted study in Ghana has gathered evidence of the demographic and health impacts of community-based family planning and health programs. The study tested the hypothesis that mobilizing health sector and cultural resources could reduce fertility and childhood mortality in a traditional rural area with high mortality, constrained development conditions, and minimal use of modern family planning. In the three years following the introduction of community-based services, fertility declined by 16 percent and early childhood mortality by 38 percent. This dramatic impact prompted the gov-

ernment to make the intervention the national model for primary health care development.

Preventing Mother-to-Child Transmission of HIV. The governments of Kenya and Zambia are testing comprehensive services for preventing mother-to-child HIV transmission in antenatal clinics. USAID is supporting these activities with assessments of service acceptability, operational barriers, costs, and impacts on mother-to-child transmission, child morbidity and mortality, and maternal well-being. The program in Kenya is providing HIV-positive women with antiretroviral drugs at critical stages late in their pregnancies and during labor. In Zambia, the program links clients with programs that offer nutritional supplements, prophylaxis for tuberculosis and other opportunistic infections, counseling, economic support, and child care services. The programs are generating changes in policies, service delivery, and resource allocation.

Dysentery Treatment. USAID-supported research in Bangladesh, South Africa, and Zimbabwe has demonstrated that a three-day treatment course for dysentery is just as effective as the standard five-day course. The shorter course requires fewer pills, thus reducing cost. It also improves adherence to treatment, which helps decrease antimicrobial resistance to medications. These findings will help WHO develop new treatment guidelines.

Social Science Research

To improve program effectiveness, USAID supports social science research into individual, social, and community behaviors that affect health.

Male Participation in Reproductive Health. The USAID-funded Men in Maternity Study in India and South Africa tests a model of ante- and postnatal services designed to assess the impact of male involvement on pregnancy outcomes and reproductive health. In India, the project has succeeded in involving men in antenatal and postpartum clinics. Providers give information to clients and spouses on subjects such as family planning, diet, rest, breastfeeding, emergency preparedness, and the dual protection benefits of condoms. Over 60 percent of couples in the project interacted closely with providers and received reproductive health messages. Syphilis tests were given to 94 percent of pregnant women.

Photo by Fisch, A.

Alternatives to Female Genital Cutting. In Kenya, female genital cutting is a rite of passage in over half the country's districts. In selected communities, a national nongovernmental organization has introduced an "alternative rite" intervention. A USAID-supported assessment of the intervention found that its effect on community abandonment of female genital cutting depended on sociocultural context. Where cultural support for cutting is weakening, communities are more likely to accept messages that encourage abandoning the practice and support an alternative coming-of-age ritual. To change attitudes, extensive sensitization must precede the introduction of an alternative ritual, which must be tailored to fit cultural norms for rites of passage.

Technical Innovation

Implementation of technical innovations follows the research that demonstrates their effectiveness. Recent advances have included:

Improved Oral Rehydration Salts. The World Health Organization introduced an improved formula for oral rehydration salts at the 2002 United Nations General Assembly Special Session on Children. The formula, developed after extensive USAID-supported research, will save millions of lives, reduce the severity and duration of illness caused by acute diarrhea, and result in fewer diarrhea-related hospitalizations. WHO estimates that the new formula could avert 14,000 deaths and save more than $7 for every episode of diarrhea.

Zinc as a Diarrhea Treatment. After reviewing a series of efficacy trials, WHO consultants concluded that zinc supplements are safe and effective for treating acute watery diarrhea in children. The studies demonstrated that 20-milligram doses of zinc for 7 to 10 days reduce the severity and duration of disease episodes. In order to facilitate scaling up the use of zinc treatment, USAID is testing its effectiveness and acceptability in multicountry trials.

Natural Family Planning. USAID has developed and tested a new natural method of family planning known as the "Standard Days Method." In clinical trials, the method was found to be more than 95 percent effective, thus offering an important natural option that increases informed choice and access to family planning. The method uses a simple low-cost visual aid called "Cycle Beads" to help a woman identify the days of her menstrual cycle when she can become pregnant if she has unprotected intercourse. The method has been introduced in 11 countries, with introductions planned in seven more countries next year.

Better Measurement of Vitamin A Deficiency. USAID has supported the development of an inexpensive tool for assessing the vitamin A levels of populations. The "retinol-binding protein enzyme immunoassay" is designed to determine the need for and efficacy of vitamin A supplementation within a given population. The test provides rapid quantitative results and can reduce the need to transport specimens to central laboratories. Before this tool became available, there were no rapid, inexpensive ways to assess vitamin A deficiency in specific populations.

Photo provided by JHU/CCP

Health Systems Strengthening

To strengthen health care financing in developing countries, USAID supports the use of national, regional, and disease-specific health accounts to improve the availability and transparency of health care financing information. USAID also promotes community-based insurance programs to overcome financial barriers to care. USAID programs support quality assurance by working with host-country counterparts to redesign services and develop policies that address service delivery needs, performance, and efficiency. As global initiatives increase world drug supplies, USAID is raising awareness of the need for drug management systems and providing technical assistance to help health sectors improve their needs estimates and their drug selection, procurement, distribution, and utilization procedures.

Assessing HIV Interventions. A USAID-funded project has developed a methodology to assess the costs and benefits of HIV/AIDS interventions. Researchers and program managers have adopted the methodology to document and support expanded access to prevention and care

services. In South Africa, one of the most promising nonprofit treatment initiatives uses the approach to show that providing treatment for employees with AIDS is a profitable investment for businesses.

Using Survey Data to Strengthen Nutrition Programs. Demographic and Health Surveys (DHS) continue to provide policymakers with national data on population, child survival, and health issues. In India, the DHS found high rates of anemia among children. Based on these findings, USAID and Indian counterparts included iron supplements in the Minimum Package for Nutrition for children. As a result of DHS data showing that malnutrition is more prevalent and serious in children less than 2 years old, growth promotion programs in El Salvador, Ghana, Guatemala, Honduras, Nicaragua, Senegal, Uganda, and Zambia are now focusing on very young children.

Community-Based Health Insurance in Senegal. High and unpredictable health care costs prevent many poor families in Senegal from seeking care. In 1999, women belonging to a rural community group decided to create a mutual health organization to help defray health care costs. USAID support helped the group organize, develop a benefits package, and contract with service providers. Through the project, women and their families have access to free consultations and prescriptions in 10 contracted health centers and to 10 days of hospitalization in two high-quality hospitals. The project had a 13-fold increase in membership in its first three years.

Improving Antibiotic Use in Russia. USAID has funded efforts in obstetric hospitals in St. Petersburg to improve patient outcomes, minimize excessive antibiotic use, and reduce costs through appropriate antibiotic use. USAID quality improvement activities helped develop and implement a simple evidence-based clinical practice guideline for use of antibiotics in caesarean sections. A follow-up study found that patients managed under the new guidelines were more likely to receive antibiotics when indicated (90 percent vs 20 percent), more likely to receive the appropriate antibiotic (90 percent vs 20 percent), and less likely to receive an excessively broad or prolonged antibiotic regimen (0 percent vs 75 percent). The cost of antibiotic prophylaxis and total antibiotic costs per caesarean section were reduced by more than two-thirds after the guidelines were implemented.

Strengthening Drug and Therapeutics Committees. USAID supported 10 training courses, reaching 320 participants from 48 countries, to strengthen drug and therapeutics committees. These committees can help developing-country hospitals improve their drug selection procedures, treatment guidelines, and drug use practices. Such improvements often translate into cost savings while also helping to contain antimicrobial resistance.

VIII. PVO Partnerships

Photo by Colvey, S.

VIII. PVO Partnerships

USAID uses three funding mechanisms for working with private voluntary organizations (PVOs) – USAID/Washington-funded agreements, Mission-funded agreements, and the Child Survival Grants Program (CSGP). All three funding mechanisms allow the Agency to continue its support for PVOs in child survival activities. This chapter describes only those activities funded by the CSGP, which are separate from activities funded by USAID/Washington and USAID Missions described in the other sections of this report.

USAID has partnered with PVOs through the Grants Program since 1985 to implement community-based child survival, health, disease control, and basic education programs worldwide. During fiscal year 2002, CSGP funded 73 projects in 33 countries; 25 PVOs and local partners implemented these projects. Since the Program began, it has funded over 300 programs in 33 countries. In 2002, it provided $17 million in support of 20 new projects.

Photo by IDRC/McGee, N.

USAID holds participating PVOs to the highest technical standards in promoting infant, child, and maternal health. At the same time, the PVOs also focus on strengthening the organizational, managerial, and technical capacities of their local partners. PVOs have established strong local partnerships and programs in some of the world's hardest-to-reach areas. They have also integrated CSGP-funded programs with programs in food aid, microcredit, water and sanitation, agriculture, and humanitarian relief for the greatest possible impact.

USAID Strategy and Interventions

Partnering with local communities, nongovernmental organizations, health centers, and health ministries, CSGP-funded projects address immunizations, nutrition, acute respiratory infections, control of diarrheal diseases, malaria, maternal and newborn care, birth spacing, breastfeeding, integrated management of childhood illnesses, and HIV/AIDS. USAID supports integrated programs to provide these needed services most effectively. Under the Program, PVOs develop and implement strategies and approaches that can be fully integrated at community, district, regional, or national levels.

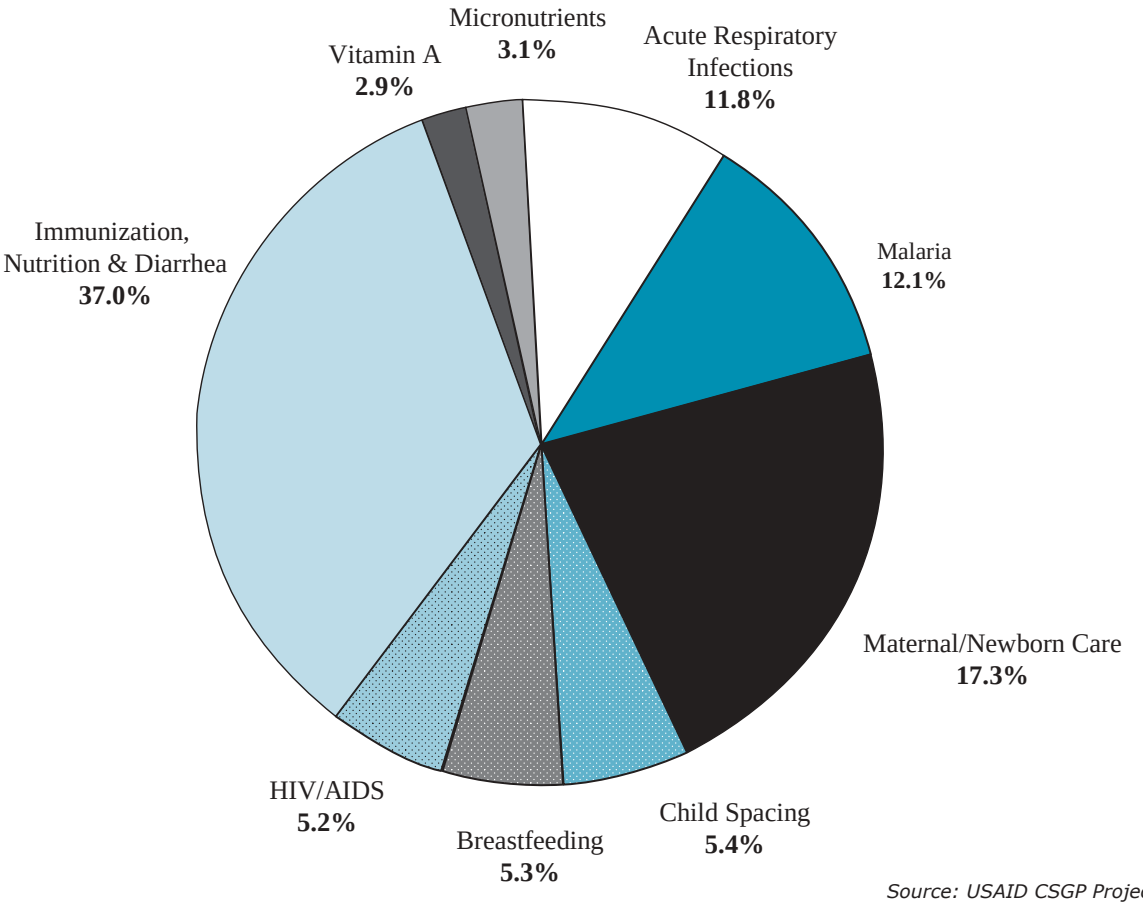
USAID also supports scaling up effective programs so their benefits reach the greatest number of people. Building the capacity of local partners is key to scaling up. The Program helps PVOs strengthen their local partners' capacity to increase program coverage in addition to improving their abilities in program design, implementation, and evaluation.

The Grants Program provides PVOs with the necessary resources, training, and technical assistance to:

- Achieve program objectives that improve the health of children and mothers in measurable and equitable ways

Figure 9

CSGP Project
Composite Intervention Mix
July 2002 (N=73)



Source: USAID CSGP Project Reports

- Increase collaboration with USAID Missions and other in-country donors and agencies in order to expand program reach and impacts
- Build the capacity of local partners to design, implement, and evaluate quality child survival and health programs

Key Achievements

Reducing Immunization Costs in Bolivia. In Bolivia, the International Eye Foundation and its local partner changed how they deployed their mobile medical units after receiving the findings of a cost-effectiveness analysis of their immunization project. Instead of traveling back to headquarters, mobile team members were lodged in remote locations, which reduced fuel costs and enabled teams to visit more sites. Due to this arrangement, costs to fully immunize one child decreased by 72 percent, and the program reached 80 percent of the targeted population.

Improving Nutrition Education in Senegal. In western Senegal, grandmothers have a very influential role in maternal and child health. Accordingly, the Christian Children's Fund developed a nutrition education project to encourage grandmothers to promote improved pregnancy-related nutritional practices (such as reduced work and improved diet) and infant feeding practices (such as breastfeeding and complementary feeding) among women of

reproductive age. Significant changes occurred in the nutritional knowledge of grandmothers, their advice to women of reproductive age, and the younger women's nutritional practices. Both the grandmothers' and younger women's knowledge of nutritional practices related to pregnancy and infant feeding increased from about 30 to 90 percent.

Disseminating Health Information in Africa. Africare has carried out a community mobilization campaign in several sub-Saharan African countries to disseminate information on key health practices related to childhood illnesses. The information encourages mothers and caretakers to seek care for their children at health facilities. In project areas, sick child consultations increased 97 percent, while in non-project areas there was a 50 percent decrease.

Improved Use of Community Health Data in Peru. In Peru, CARE has used community-based data in training workshops to enhance the analysis skills of community health workers and Ministry of Health staff and increase their collaboration. The strategic use of community-based data on childhood pneumonia, diarrhea, and maternal attendance for prenatal care has led to better detection of weaknesses in the health system and improved the targeting of community health care needs. Attendance for prenatal care at Ministry facilities increased from 38 to 73 percent during the project period, and the percentage of children with suspected pneumonia seen by a qualified medical provider increased from 32 to 60 percent.

Improving Ante- and Postnatal Care in Mozambique. A Health Alliance International project in the Sofala and Manica provinces of Mozambique provides training for traditional birth attendants. The project also uses drama presentations and radio messages to alert mothers to key danger signs of obstetric emergencies. In Sofala, the percentage of women who receive assistance at delivery from a trained traditional birth attendant increased from 30 to over 50 percent. Postnatal care visits to new mothers increased from 30 to over 70 percent in Manica and from 25 to almost 50 percent in Sofala. The proportion of pregnant women who receive syphilis screenings and treatment according to protocols increased from 40 to 84 percent in Manica and from 20 to over 90 percent in Sofala. Health Alliance International's prenatal syphilis screening program is so successful it has become a model for best practices in Mozambique and Southern Africa.

Looking Forward

As part of USAID's recent reorganization, the scope of the Grants Program has been expanded in order to capitalize on the strategic niche that PVOs hold at community, district, regional, and national levels. In October 2002, the Program was renamed the Child Survival and Health Grants Program and transferred to the Bureau for Global Health's Office of Health, Infectious Diseases and Nutrition. The continuing program will support PVO efforts on broader health issues, including family planning and infectious diseases.

Photo provided by UNICEF

Conclusion

Photo by Fisch, A.

Investing in the health of the world's population contributes to global economic development, poverty reduction, a sustainable environment, and regional security. In addition to protecting human health and enhancing the lives of people in developing countries – especially women and children – USAID's child survival and health programs affect public health in the United States by preventing the spread of infectious diseases. Addressing humanitarian needs is also an acknowledged element of our national security interests and enhances our relations with other countries.

New approaches in partnerships will enable USAID to coordinate programs, incorporate new strategies, and leverage substantial private resources. USAID will continue to identify and implement the most effective and cost-effective interventions to address maternal and child health, nutrition, reproductive health, HIV/AIDS, and infectious diseases such as malaria and tuberculosis in the world's poorest countries. The Agency will also focus renewed efforts on enhancing science and technology, disseminating successful new tools and programs, and integrating them into national health systems and responses to health problems.

These are global issues with global consequences. The health of a population directly affects its productivity, and unchecked diseases in other countries pose threats to our own. We can save lives and help build stable and secure civil societies. In so doing, the world will be safer, more prosperous, and freer than ever before.

Financial Annex

Funding Tables

Table 1: FY 2002 Total USAID Health Budget by Program Category and Bureau

($ Thousands)

Program Category	AFR	ANE	E&E	LAC	DCHA	GH	Int'l Partners	PPC	Total
Child Survival & Maternal Health	88,210	97,100	31,640	35,202	21,881	56,770	59,500	1,410	391,713
Vulnerable Children	11,201	9,474	7,470	1,350	–	2,844	–	–	32,339
HIV/AIDS	196,889	56,987	18,182	33,250	–	62,000	133,000	1,000	501,308
Infectious Diseases	54,118	22,427	16,618	23,013	4,012	50,640	10,000*	1,190	182,018
Family Planning & Reproductive Health	85,900	120,517	24,983	62,500	–	150,800	–	1,800	446,500
UNICEF	–	–	–	–	–	–	120,000	–	120,000
Total	436,318	306,505	98,893	155,315	25,893	323,054	322,500	5,400	1,673,878

* This amount represents a portion of the FY02 contribution to GFATM.

Source: USAID, Bureau for Policy and Program Coordination, Office of Strategic Planning

Table 2: FY 2002 Child Survival and Health Programs Fund Budget by Program Category and Bureau

($ Thousands)

Program Category	AFR	ANE	E&E	LAC	DCHA	GH	Int'l Partners	PPC	Total
Child Survival & Maternal Health	88,210	57,027	–	35,202	21,881	56,770	59,500	1,410	320,000
Vulnerable Children	11,201	9,474	131	1,350	–	2,844	–	–	25,000
HIV/AIDS	183,250	53,500	–	27,250	–	62,000	108,000	1,000	435,000
Infectious Diseases	54,118	22,027	–	23,013	4,012	50,640	10,000*	1,190	165,000
Family Planning & Reproductive Health	85,900	72,000	–	58,000	–	150,800	–	1,800	368,500
UNICEF	–	–	–	–	–	–	120,000	–	120,000
Total	422,679	214,028	131	144,815	25,893	323,054	297,500	5,400	1,433,500

* This amount represents a portion of the FY02 contribution to GFATM.

Source: USAID, Bureau for Policy and Program Coordination, Office of Strategic Planning

Table 3: FY 2002 Child Survival and Health Programs Fund Budget by Program Category and Country

($ Thousands)

Bureau/Country	CS/MH		VC	HIV/AIDS	Infectious Diseases			FP/RH	Total
	Child Survival & Maternal Health	Polio	Vulnerable Children	HIV/AIDS	TB	Malaria	AMR, Surveillance, & Other ID	Family Planning & Reproductive Health	
AFRICA									
Angola	1,375	2,600	1,581	2,500	–	1,000	–	–	9,056
Benin	1,800	100	–	2,005	–	1,500	–	2,438	7,843
Burundi	400	100	–	–	–	–	–	–	500
Congo, Dem. Rep of	6,795	3,133	3,550	3,500	1,200	1,300	700	1,000	21,178
Eritrea	2,500	200	–	1,750	–	600	–	500	5,550
Ethiopia	3,017	2,900	–	11,250	1,750	1,100	800	4,940	25,757
Ghana	3,800	500	–	5,500	–	900	1,000	7,255	18,955
Guinea	2,200	250	–	2,200	–	–	–	2,300	6,950
Kenya	1,300	–	–	17,200	1,750	1,200	–	6,113	27,563
Liberia	1,100	400	–	–	–	–	–	500	2,000
Madagascar	2,900	75	–	1,250	–	300	–	4,200	8,725
Malawi	1,460	75	–	8,500	1,500	1,800	–	2,280	15,615
Mali	3,700	300	–	3,167	–	800	500	6,321	14,788
Mozambique	4,000	100	–	7,500	–	600	400	5,177	17,777
Namibia	–	–	350	1,500	–	–	–	–	1,850
Nigeria	3,850	2,000	–	14,500	–	2,900	–	12,816	36,066
Rwanda	1,400	50	3,000	6,500	–	600	–	750	12,300
Senegal	2,500	150	500	5,000	1,000	2,500	–	3,355	15,005
Sierra Leone	–	234	841	–	–	–	–	–	1,075
Somalia	500	–	–	–	–	–	–	–	500
South Africa	2,000	–	379	15,000	2,000	–	–	1,125	20,504
Sudan	500	–	–	–	–	–	–	–	500
Tanzania	2,400	–	–	8,500	–	600	1,200	4,000	16,700
Uganda	2,700	–	1,000	20,000	1,750	3,000	–	5,200	33,650
Zambia	5,150	80	–	18,500	–	4,000	–	3,100	30,830
Zimbabwe	–	–	–	6,450	–	–	–	–	6,450
AFR/SD	10,100	4,000	–	3,400	2,511	4,807	4,250	2,523	31,591
REDSO/East	2,050	200	–	4,800	400	1,100	–	1,025	9,575
Southern Africa Reg.	–	–	–	4,000	–	–	–	–	4,000
WARP	913	–	–	8,778	–	800	–	8,982	19,826
TOTAL	**70,410**	**17,800**	**11,201**	**183,250**	**13,861**	**31,407**	**8,850**	**85,900**	**422,679**

Table 3 *(continued)*: FY 2002 Child Survival and Health Programs Fund Budget by Program Category and Country

($ Thousands)

Bureau/Country	CS/MH		VC	HIV/AIDS	Infectious Diseases			FP/RH	Total
	Child Survival & Maternal Health	Polio	Vulnerable Children	HIV/AIDS	TB	Malaria	AMR, Surveillance, & Other ID	Family Planning & Reproductive Health	
ASIA/NEAR EAST									
Afghanistan	2,000	–	2,000	–	–	–	–	–	4,000
Bangladesh	11,500	150	–	3,200	600	–	–	24,500	39,950
Cambodia	–	–	–	12,000	2,200	800	–	–	15,000
India	7,800	3,778	–	12,200	4,200	–	1,800	11,900	41,678
Indonesia	14,700	300	668	7,300	2,000	600	–	10,000	35,568
Laos	–	–	–	1,000	–	–	–	–	1,000
Morocco	2,800	–	–	–	–	–	–	1,800	4,600
Nepal	4,700	–	–	6,700	–	600	1,500	6,500	20,000
Pakistan	3,000	100	–	500	–	–	–	1,400	5,000
Philippines	4,899	–	–	1,500	2,300	400	1,500	15,000	25,599
Sri Lanka	–	–	300	–	–	–	–	–	300
Thailand	–	–	–	1,000	–	–	–	–	1,000
Vietnam	500	–	506	3,100	–	–	963	–	5,069
ANE Regional	800	–	6,000	5,000	1,200	1,362	2	900	15,264
TOTAL	**52,699**	**4,328**	**9,474**	**53,500**	**12,500**	**3,762**	**5,765**	**72,000**	**214,028**
EUROPE AND EURASIA									
Kosovo	–	–	131	–	–	–	–	–	131
TOTAL	–	–	**131**	–	–	–	–	–	**131**
LATIN AMERICA AND THE CARIBBEAN									
Bolivia	3,700	–	–	650	831	600	910	13,000	19,691
Brazil	–	–	1,150	5,000	3,000	–	–	–	9,150
Dominican Republic	2,500	–	–	4,000	1,400	–	–	1,632	9,532
El Salvador	8,000	–	–	500	250	–	2,256	4,647	15,653
Guatemala	5,700	–	–	500	–	–	–	9,500	15,700
Guyana	–	–	–	1,000	–	–	–	–	1,000
Haiti	283	–	–	–	–	–	–	355	638
Honduras	2,750	–	–	3,500	650	220	57	6,000	13,177
Jamaica	–	–	–	1,300	–	–	25	1,796	3,121
Mexico	–	–	–	1,500	4,009	–	–	–	5,509
Nicaragua	3,550	–	–	500	–	–	550	3,870	8,470
Paraguay	–	–	–	–	–	–	–	2,525	2,525
Peru	5,285	–	200	750	430	1,000	2,000	14,000	23,665
Caribbean Regional	–	–	–	3,550	–	–	–	–	3,550
G/CAP	–	–	–	4,000	–	–	–	–	4,000
LAC/RSD-SPO	3,262	172	–	500	1,430	2,295	1,100	675	9,434
TOTAL	**35,030**	**172**	**1,350**	**27,250**	**12,000**	**4,115**	**6,898**	**58,000**	**144,815**

Table 3 *(continued)*: FY 2002 Child Survival and Health Programs Fund Budget by Program Category and Country

($ Thousands)

Bureau/Country	CS/MH		VC	HIV/AIDS	Infectious Diseases			FP/RH	Total
	Child Survival & Maternal Health	Polio	Vulnerable Children	HIV/AIDS	TB	Malaria	AMR, Surveillance, & Other ID	Family Planning & Reproductive Health	
CENTRAL PROGRAMS									
DCHA	21,881	–	–	–	1,639	2,373	–	–	25,893
Global Health	51,570	5,200	2,844	62,000	19,000	18,343	13,297	150,800	323,054
PPC	1,410	–	–	1,000	1,000	–	190	1,800	5,400
TOTAL	**74,861**	**5,200**	**2,844**	**63,000**	**21,639**	**20,716**	**13,487**	**152,600**	**354,347**
INTERNATIONAL PARTNERSHIPS									
GFATM	–	–	–	40,000	5,000	5,000	–	–	50,000
GAVI	53,000	–	–	–	–	–	–	–	53,000
UNAIDS	–	–	–	18,000	–	–	–	–	18,000
IAVI	–	–	–	10,000	–	–	–	–	10,000
GAIN	4,000	–	–	–	–	–	–	–	4,000
IDD	2,500	–	–	–	–	–	–	–	2,500
Microbicides	–	–	–	15,000	–	–	–	–	15,000
CPF	–	–	–	25,000	–	–	–	–	25,000
UNICEF	–	–	–	–	–	–	–	–	120,000
TOTAL	**59,500**	–	–	**108,000**	5,000	5,000	–	–	**297,500**
Subtotal CSH	**292,500**	**27,500**	**25,000**	**435,000**	**65,000**	**65,000**	**35,000**	**368,500**	**1,313,500**
UNICEF	–	–	–	–	–	–	–	–	**120,000**
GRAND TOTAL CSH									**1,433,500**

Table 4: FY 2002 USAID's Health Budget From Other Accounts by Program Category and Country

($ Thousands)

Bureau/Country	CS/MH		VC	HIV/AIDS	Infectious Diseases			FP/RH	Total
	Child Survival & Maternal Health	Polio	Vulnerable Children	HIV/AIDS	TB	Malaria	AMR, Surveillance, & Other ID	Family Planning & Reproductive Health	
AFRICA									
Angola	-	-	-	400	-	-	-	-	400
Madagascar	-	-	-	400	-	-	-	-	400
Namibia	-	-	-	400	-	-	-	-	400
Nigeria	-	-	-	1,000	-	-	-	-	1,000
REDSO/ESA	-	-	-	500	-	-	-	-	500
South Africa	-	-	-	939	-	-	-	-	939
Sub-Saharan Africa (PL-480)	-	-	-	10,000	-	-	-	-	10,000
TOTALS	-	-	-	**13,639**	-	-	-	-	**13,639**
ASIA AND NEAR EAST									
Cambodia	4,000	-	-	-	-	-	-	3,000	7,000
East Timor	-	-	-	1,000	-	-	-	-	1,000
Egypt	30,473	-	-	1,187	400	-	-	23,348	55,408
Indonesia	-	-	-	1,000	-	-	-	-	1,000
Jordan	4,900	-	-	300	-	-	-	12,800	18,000
Philippines	-	-	-	-	-	-	-	2,000	2,000
West Bank/Gaza	-	-	-	-	-	-	-	6,369	6,369
Yemen	700	-	-	-	-	-	-	1,000	1,700
TOTALS	**40,073**	-	-	**3,487**	**400**	-	-	**48,517**	**92,477**
EUROPE AND EURASIA									
Albania	105	-	-	350	2	-	8	3,310	3,775
Armenia	4,110	-	1,118	500	15	-	105	2,758	8,606
Azerbaijan	836	-	-	174	32	-	143	1,815	3,000
Bosnia	-	-	1,000	-	-	-	-	-	1,000
Bulgaria	-	-	-	-	-	-	-	511	511
Croatia	-	-	-	100	-	-	-	-	100
Georgia	896	-	94	-	1,598	-	513	1,217	4,318
Kazakhstan	3,136	-	-	838	466	-	746	814	6,000
Kosovo	-	-	-	750	150	-	-	500	1,400
Kyrgyzstan	2,063	-	-	580	308	700	576	273	4,500
Moldova	96	-	-	-	2,613	-	-	204	2,913
Romania	199	-	2,810	945	150	-	-	2,755	6,859
Russia	1,536	-	2,117	3,807	1,864	-	251	4,040	13,615
Serbia	-	-	-	-	-	-	-	1,500	1,500
Tajikistan	4,328	-	-	1,600	450	261	372	239	7,250
Turkmenistan	779	-	-	185	237	-	31	268	1,500
Ukraine	1,665	-	-	1,411	850	-	177	2,294	6,396
Uzbekistan	9,829	-	-	4,000	1,992	-	381	798	17,000
CAR Regional	120	-	-	880	-	-	-	-	1,000
Eurasia Regional	1,606	-	100	1,076	657	-	256	905	4,600
Europe Regional	336	-	100	986	693	-	23	782	2,919
TOTALS	**31,640**	-	**7,339**	**18,182**	**12,076**	**961**	**3,581**	**24,983**	**98,762**

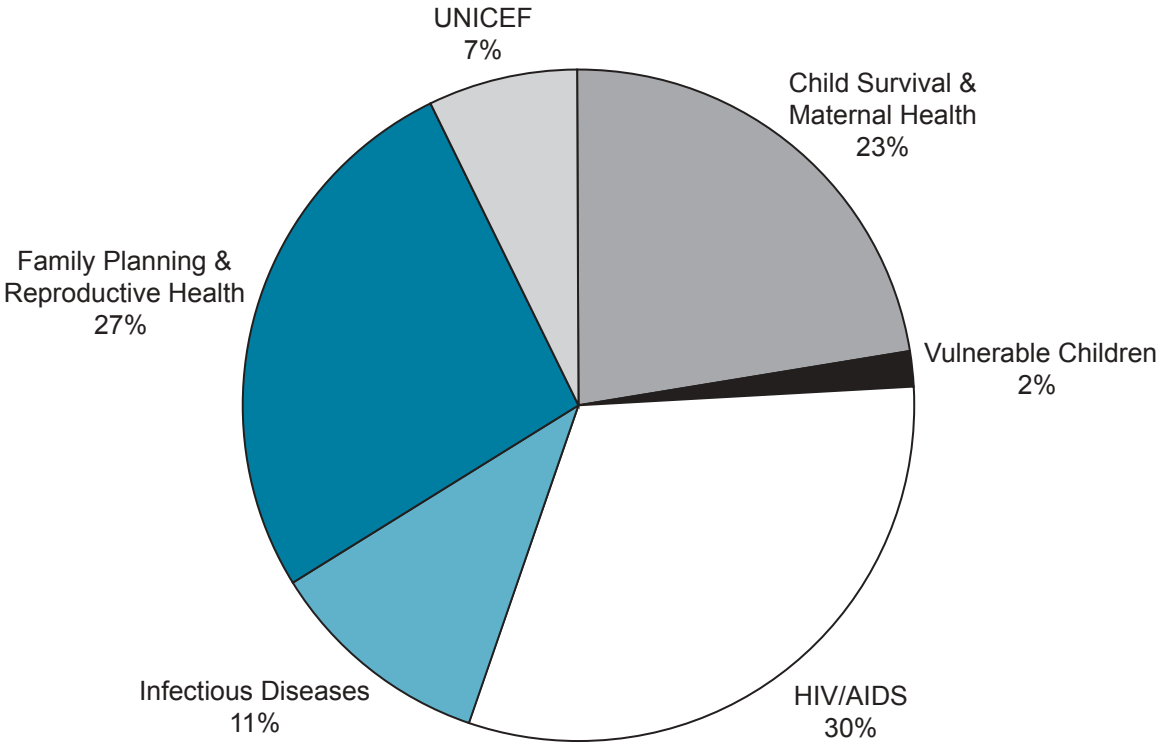
Table 4 *(continued)*: FY 2002 USAID's Health Budget From Other Accounts by Program Category and Country

($ Thousands)

Bureau/Country	CS/MH		VC	HIV/AIDS	Infectious Diseases			FP/RH	Total
	Child Survival & Maternal Health	Polio	Vulnerable Children	HIV/AIDS	TB	Malaria	AMR, Surveillance, & Other ID	Family Planning & Reproductive Health	
LATIN AMERICA AND THE CARIBBEAN									
Haiti	–	–	–	4,000	–	–	–	4,500	8,500
Caribbean Regional	–	–	–	2,000	–	–	–	–	2,000
TOTALS	–	–	–	**6,000**	–	–	–	**4,500**	**10,500**
INTERNATIONAL PARTNERSHIPS									
GFATM	–	–	–	25,000	–	–	–	–	25,000
TOTALS	–	–	–	**25,000**	–	–	–	–	**25,000**
Total Other Accounts	**71,713**	–	**7,339**	**66,308**	**12,476**	**961**	**3,581**	**78,000**	**240,378**
Subtotal CSH	**292,500**	**27,500**	**25,000**	**435,000**	**65,000**	**65,000**	**35,000**	**368,500**	**1,313,500**
UNICEF	–	–	–	–	–	–	–	–	**120,000**
Total CSH	–	–	–	–	–	–	–	–	**1,433,500**
Total All Accounts	**364,213**	**27,500**	**32,339**	**501,308**	**77,476**	**65,961**	**38,581**	**446,500**	**1,673,878***

* The "Total All Accounts" line total includes the $120,000 for UNICEF.

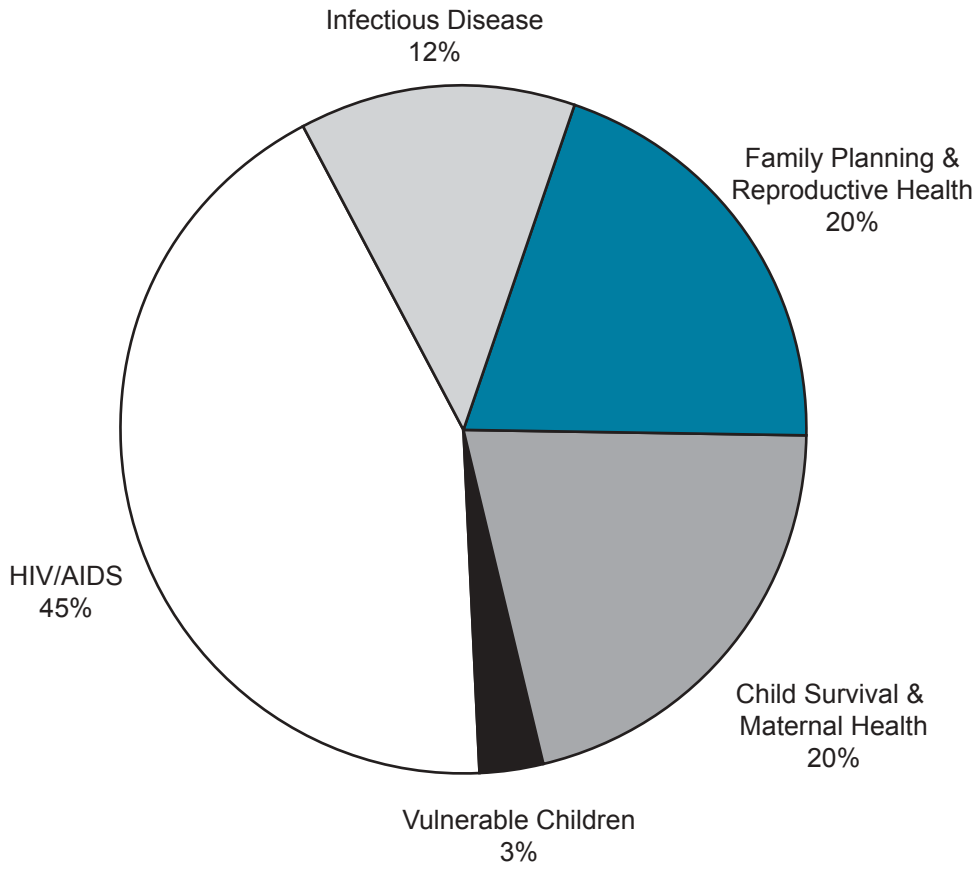
FY 2002 Total Health Budget
by Primary Funding Category



FY 2002 Total Funding= $1,673,878,000

Source: USAID, Bureau for Policy and Program Coordination, Office of Strategic Planning

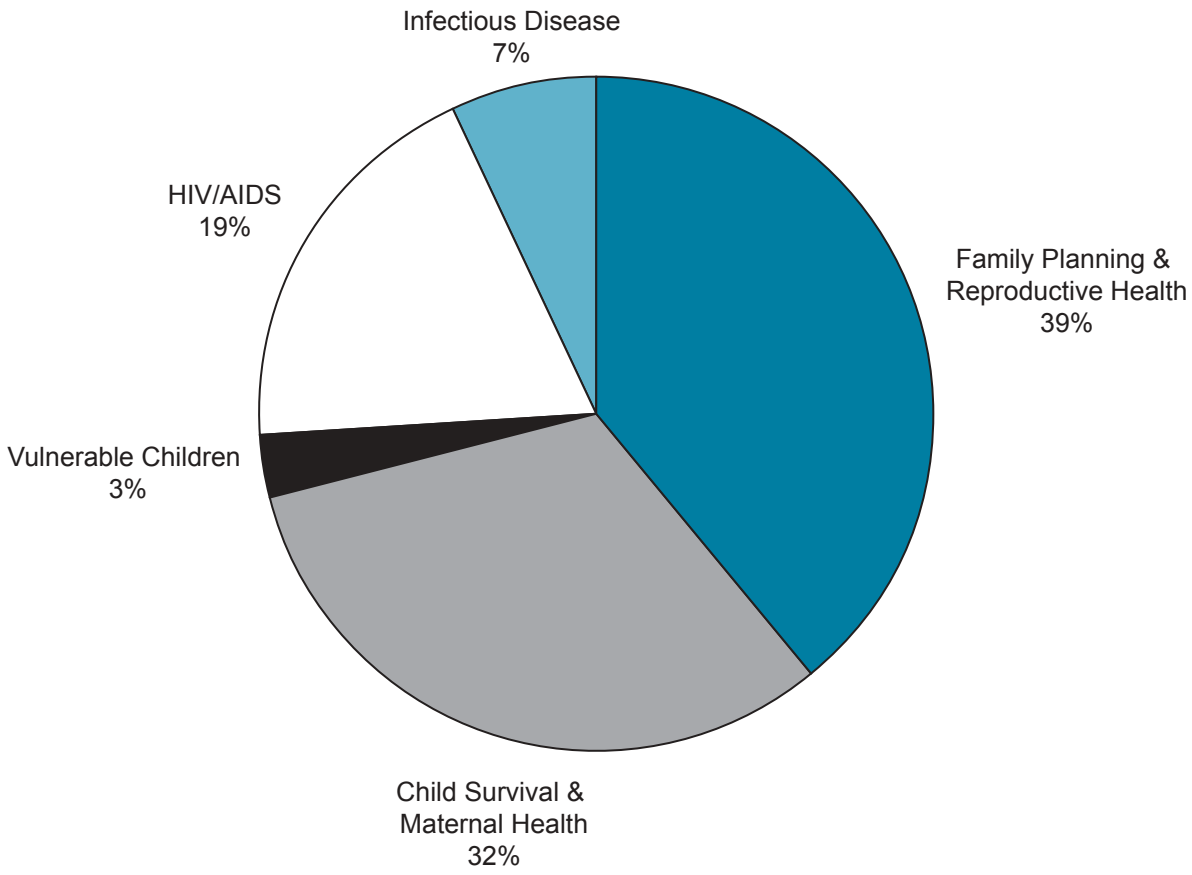
FY 2002 Africa Region Total Health Budget by Primary Funding Category



FY 2002 Total Funding = $436,318,000

Source: USAID, Bureau for Policy and Program Coordination, Office of Strategic Planning

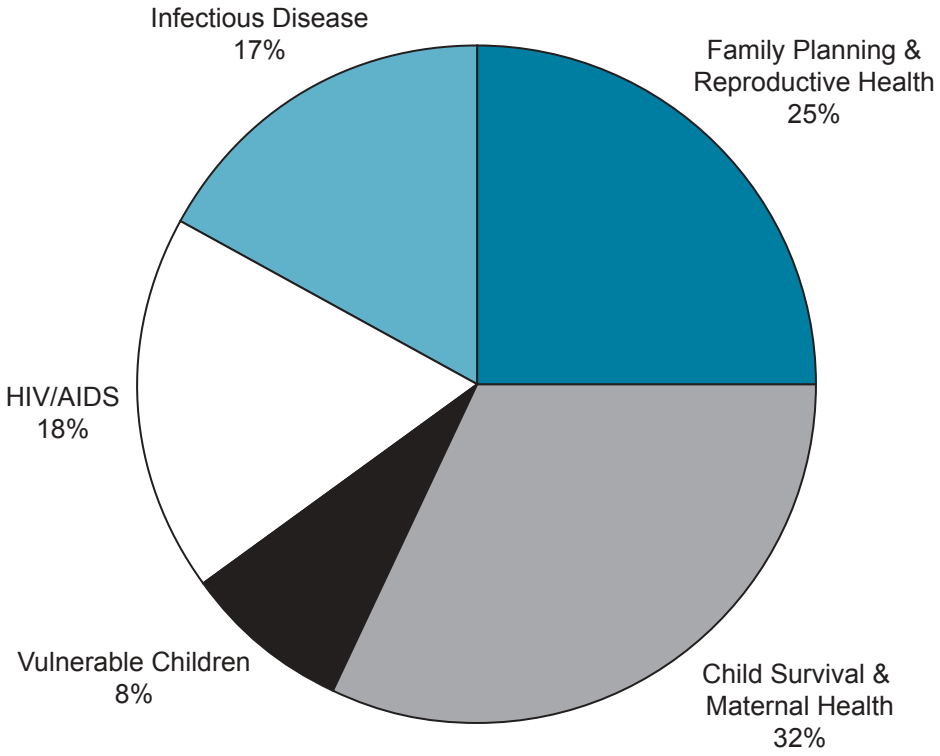
FY 2002 Asia and Near East Region Total Health Budget by Primary Funding Category



FY 2002 Total Funding = $306,505,000

Source: USAID, Bureau for Policy and Program Coordination, Office of Strategic Planning

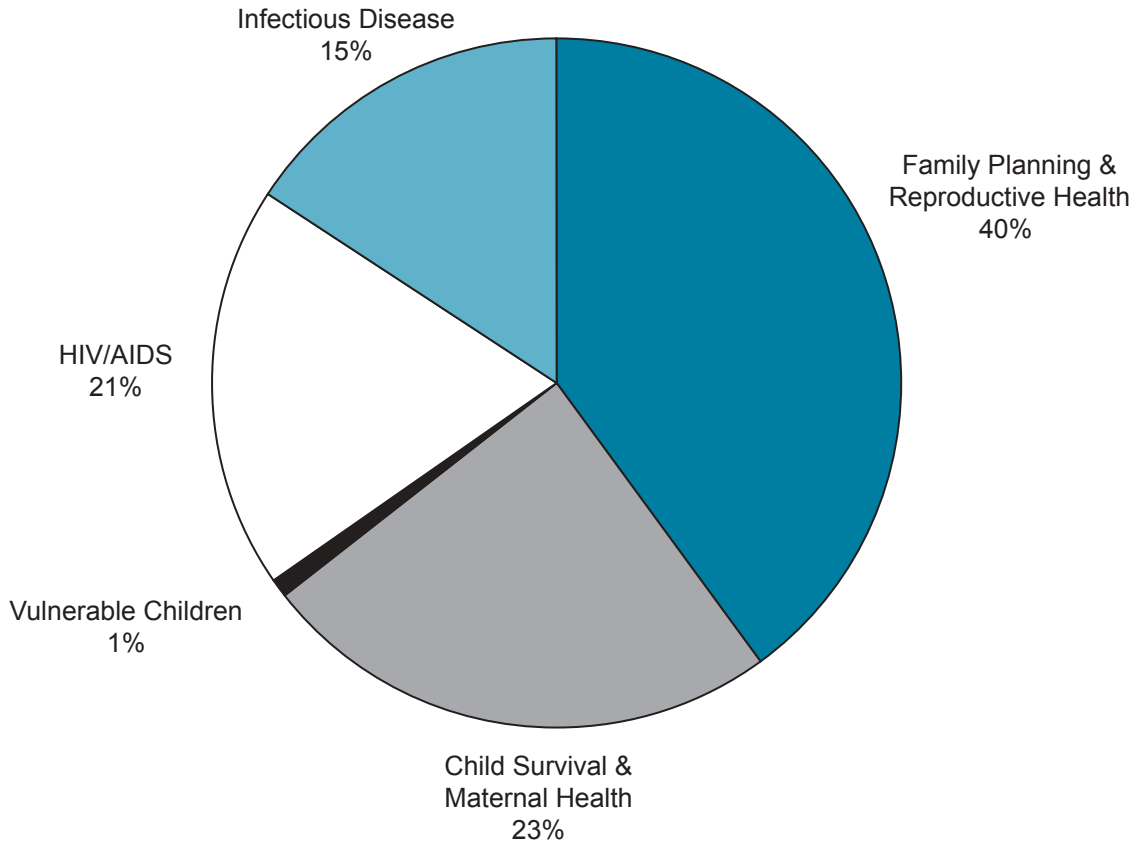
FY 2002 Europe and Eurasia Region Total Health Budget by Primary Funding Category



FY 2002 Total Funding = $98,893,000

Source: USAID, Bureau for Policy and Program Coordination, Office of Strategic Planning

FY 2002 Latin America and the Caribbean Region Total Health Budget by Primary Funding Category



FY 2002 Total Funding = $155,315,000

Source: USAID, Bureau for Policy and Program Coordination, Office of Strategic Planning

U.S. Agency for International Development
Washington, D.C.

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